



Cameron, Kirsteen Sarah (2006) *Needs-led assessment in health and social care : a community-based comparative study*. PhD thesis.

<http://theses.gla.ac.uk/2984/>

Copyright and moral rights for this thesis are retained by the author

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge

This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the Author

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the Author

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given

# Needs-led Assessment in Health and Social Care: A Community-based Comparative Study

Kirsteen Sarah Cameron

B.N., R.G.N

PhD Thesis

University of Glasgow

Faculty of Medicine: Division of Community-based Sciences, Public  
Health and Health Policy Section

September 2006



## **ABSTRACT**

The assessment of need underpins the delivery of community-based care. Following the NHS and Community Care Act (1990), the principle of needs-led assessment was reinforced as it applied to the assessment and care management process. Translation of needs-led assessment into practice in Scotland has been further influenced by policy-based organisational change including the introduction of Single Shared Assessment and Community Health Partnerships. Each endeavours to facilitate collaborative working between agencies, based upon the needs of clients, with greater emphasis on consumer choice. Amidst external reorganisation, practitioners face internal decision-making pressures: particularly where needs-led assessment is a requirement within resource constrained, rationed organisations. Assessment of need and addressing need constitute two components of a decision-making process influenced by external and internal factors. This study seeks to describe the political and practice landscape within which needs-led assessment exists, identify and explore factors which influence needs-led assessment, and consider the practice implications of this policy driver for community-based practitioners across the main disciplines of health and social care.

Following a short pilot, the main study was undertaken using sequenced vignettes within a semi-structured interview involving 105 social work, health and housing staff. Key findings indicated a lack of consensus around definitions of need and assessment with perceptions based upon a medical or social model of care or a professionally or personally-driven assessment of need. A preoccupation with the outcome of assessments caused many respondents to describe needs with reference to the interventions or resources required to address them. The practice of needs-led assessment, according to study results, was hampered by an awareness of resource availability, concerns over client compliance and risk and, an underlying alignment to the values and principle upheld by the employing discipline.

## **ACKNOWLEDGEMENTS**

I wish to thank all the people who assisted me with this study and supported the work in a variety of ways. In particular I am grateful to the staff who participated in the study and supported the pilot phase.

I wish to thank my employers for accommodating study-related activity during office hours and whose expertise within the study field made this opportunity possible and enjoyable.

I wish to express my thanks to my Supervisor, Professor Alison Petch who endured endless hours of meetings, telephone discussions and emails and provided invaluable insight and guidance during the design, development and delivery of the thesis. Also I would like to thank Dr Elizabeth Campbell who, in the latter stages of the study very gently provided a sharp stick to ensure momentum was maintained and whose advice in editing was invaluable.

Lastly but not leastly I would like to thank my family and friends who now know more about needs-led assessment than the average citizen and have persevered with patience, promise and a distinct lack of complaint.



## **STATEMENT OF AUTHENTICITY**

This Thesis is an original and authentic piece of work carried out by myself. I have fully acknowledged and referenced all secondary sources of information. This Thesis has not been presented in whole or in part elsewhere. I have read the Examination Regulations and am fully aware of the potential consequences of any breach of them.

Signed:

Dated:

## **CONFIDENTIALITY STATEMENT**

Participants engaged voluntarily in the pilot processes and interviews which provided the basis for this Thesis. Every effort was made to ensure that neither individuals nor teams were identifiable by role, responsibility, geography.

Tape recording of interviews was carried out with the full and explicit knowledge and permission of the study participant and their line managers.

Signed:

Dated:

## **TABLE OF CONTENTS**

1	Positioning The Research In A Wider Context .....	1
1.1	Introduction .....	1
1.2	Need: Common Concepts and Definitions .....	10
1.3	The Concept of Need and Need Management in Practice .....	17
1.4	The Definition of Need in Health and Social Care.....	19
1.5	Practical Applications of Definitions of Need in Health and Social Care .....	24
1.6	Chapter Conclusions .....	26
2	The Assessment and/or Identification of Need .....	27
2.1	Chapter Introduction .....	27
2.2	The Value Base of Needs Assessment.....	27
2.3	The Construction of Needs Assessment .....	28
2.4	Consideration of Models to Undertake Needs-led Assessment ..	30
2.5	Disempowering Components of Needs-led Assessments.....	34
2.6	Factors Affecting Needs-led Assessment at Practice Level .....	38
2.7	Needs Assessment Approaches in Health and Social Care.....	39
2.8	The Inclusion of Service Users and their Carers in Needs Assessment .....	43
2.9	Defining the Assessment Process.....	44
2.10	Assessment, Care Planning and Resource Allocation for Individuals and Communities .....	51
2.11	Chapter Conclusions .....	54
3	Methodology - Justification and Design.....	57
3.1	Chapter Introduction (including Research Questions) .....	57
3.2	Qualitative Methodology – an Overview .....	58
3.3	The Choice and Rationale of Study Research Methodology.....	59
3.4	A Critique of the Qualitative Interview Methodology using Vignettes to Elicit Responses to Broad Based Concepts .....	65
3.5	Chapter Conclusions .....	68
4	The Pilot Phase of the Study .....	69
4.1	Chapter Introduction .....	69
4.2	Aims and Vignette Design Process for the Purpose of the Study	69

4.3	Pilot Stage 1: The Development of Vignettes and Question Criteria .....	71
4.4	Pilot Stage 2: User Testing (1) .....	75
4.5	Pilot Stage 3: Further Develop Vignettes and Refine Questions .....	77
4.6	Pilot Stage 4: User Testing (2) .....	79
4.7	Pilot Stage 5: Pilot Vignette Sequence and Questions .....	80
4.8	Pilot Stage 6: Pilot Evaluation .....	81
4.9	Pilot Stage 7: Gold Standard Responses .....	89
4.10	Chapter Conclusions .....	92
5	Application of the Main Study Methodology .....	93
5.1	Chapter Introduction .....	93
5.2	Proposed Sampling .....	93
5.3	Ethical Considerations .....	93
5.4	Study Recruitment .....	95
5.5	Characteristics of Sample Group .....	96
5.6	Chapter Conclusions .....	102
6	Needs Identified From Qualitative Interview Methodology using Vignettes .....	103
6.1	Chapter Introduction .....	103
6.2	General Overview of Responses Identified Between Professional Groups for Vignettes 1 and 2 .....	103
6.3	Carer Needs .....	107
6.4	Mental Health .....	110
6.5	Urinary Incontinence .....	113
6.6	Personal Hygiene .....	115
6.7	Mobility .....	117
6.8	Housing .....	119
6.9	Socialisation .....	122
6.10	Financial .....	124
6.11	General Observations of How Needs were Described .....	126
6.12	Responses to the Comprehensive List of Services, Professionals, Aids and Adaptations .....	128
6.13	Actions Undertaken in Order to Address Identified Needs .....	135
6.14	Chapter Conclusions .....	142
7	Analysis Of The Definition And Identification Of Need .....	144

7.1	Chapter Introduction .....	144
7.2	Overview of Definitions of Need .....	144
7.3	The Identification of Need in Practice .....	173
7.4	Chapter Conclusions .....	213
8	Analysis Of Definitions Of Assessment.....	217
8.1	Chapter Introduction .....	217
8.2	Chapter Conclusions .....	238
9	Factors Affecting Needs-led Assessment.....	240
9.1	Chapter Introduction .....	240
9.2	Overview of Responses to Study Questions Eliciting Factors which Influenced Needs-led Assessment .....	240
9.3	Chapter Conclusions .....	339
10	Conclusions from the Study .....	342
10.1	Chapter Introduction .....	342
10.2	Needs-led Assessment – Idealistic Principle or Practical Reality? .. .....	343
10.3	Consideration of Study Results within Current Scottish, Political Climate .....	359
10.4	Consideration of Conclusions and Recommendations .....	360
10.5	Questions Raised but Unanswered by the Study .....	362
10.6	Critical Reflections from the Study .....	363
10.7	Recommendations if Study was repeated.....	366
10.8	Recommendations from Study Results .....	369
	Appendix 1 Vignette Guidelines .....	i
	Appendix 2 Background Information to the Study .....	ii
	Appendix 3 Vignette Interview Preamble .....	v
	Appendix 4 Draft 1: Pilot Vignette .....	vi
	Appendix 5 Choice of Vignettes Developed.....	viii
	Appendix 6 Research Study Participant Questionnaire, vignette and questions.....	xvi
	Appendix 7 Research Study Participant Questionnaire, Vignette and Questions .....	xxii
	Appendix 8 Responses Identified from GSG regarding Needs and Interventions.....	xxviii
	Appendix 9 Participant Request Letter.....	xxxvi

## TABLE OF FIGURES

Figure 1 The Process of Developing Vignettes and Questions for use within the Study.....	71
Figure 2 Professional Profile of Sample.....	97
Figure 3 Total Number of Responses to Needs Identified from Vignette 2 compared to Vignette 1 .....	106
Figure 4 Total Number of Needs Identified with Carer's Needs in Relation to Vignette 2 Compared to Vignette 1 .....	108
Figure 5 Total Number of Needs Identified with Mental Health in Relation to Vignette 2 compared to Vignette 1.....	111
Figure 6 Total Number of Needs Identified with Urinary Incontinence in Relation to Vignette 2 Compared to Vignette 1 .....	113
Figure 7 Total Number of Needs Identified with Personal Hygiene in Relation to Vignette 2 Compared to Vignette 1 .....	116
Figure 8 Total Number of Needs Identified with Mobility in Relation to Vignette 2 Compared to Vignette 1 .....	118
Figure 9 Total Number of Needs Identified with Housing in Relation to Vignette 2 Compared to Vignette 1 .....	120
Figure 10 Total Number of Needs Identified with Socialisation in Relation to Vignette 2 Compared to Vignette 1 .....	122
Figure 11 Total Number of Needs Identified with Financial Matters in Relation to Vignette 2 Compared to Vignette 1 .....	124
Figure 12 How Needs were Described in Relation to Vignette 2 Compared to Vignette 1 .....	126
Figure 13 Services Identified from Comprehensive List by all Interviewees .....	130
Figure 14 Professionals Identified from Comprehensive List by all Interviewees .....	131
Figure 15 Aids and Adaptations Identified from Comprehensive List by all Interviewees .....	133
Figure 16 Actions Taken in Order to Meet Needs following presentation of Vignettes 1 and 2.....	136
Figure 17 Definitions of Need Identified by Interviewees.....	145

Figure 18 Factors Affecting the Identification of Need .....	174
Figure 19 Communication: Factors Volunteered which Affect the Identification and Assessment of Need .....	176
Figure 20 Information Gathering: Factors Identified which Affect the Identification and Assessment of Need .....	182
Figure 21 Perception: Factors Volunteered which Affect the Identification and Assessment of Need .....	185
Figure 22 Assessment Tool: Factors Volunteered which Affect the Identification and Assessment of Need .....	197
Figure 23 Experience: Factors Identified which Affect the Identification and Assessment of Need .....	202
Figure 24 Assessment Model: Factors Identified which Affect the Identification and Assessment of Need .....	210
Figure 25 Definitions of Assessment Identified in Study Sample.....	217
Figure 26 General Factors Identified as Influencing the Extent to which Needs could be Addressed .....	242
Figure 27 Resources: Factors Identified as Influencing the Extent to which Needs could be Addressed .....	243
Figure 28 Compliance: Factors Volunteered as Influencing the Extent to which Needs could be Addressed .....	261
Figure 29 Risk: Factors Volunteered as Influencing the Extent to which Needs could be Addressed .....	271
Figure 30 Organisational Factors Volunteered as Influencing the Extent to which Needs could be Addressed .....	283
Figure 31 Organisational Values: Factors Volunteered as Influencing the Extent to which Needs could be Addressed .....	294
Figure 32 Experience: Factors Volunteered as Influencing the Extent to which Needs could be Addressed .....	313
Figure 33 Communication: Factors Volunteered as Influencing the Extent to which Needs could be Addressed .....	321
Figure 34 Needs Assessment: Factors Volunteered as Influencing the Extent to which Needs could be Addressed .....	330
Figure 35 Attributes of a Good Assessor .....	353

## **LIST OF ABBREVIATIONS**

Study participants are referred to as interviewees, respondents, assessors and participants: where appropriate reference to their professional background or designation is provided.

Client/s is used as the general term for recipients of assessment and/or services: other terms such as patient, citizen, consumer are occasionally referred to by interviewees or other authors.

105 interviews were conducted in total (additional interviews were undertaken with GPs and housing staff for contextual reasons) therefore for all figures, n = 105

Allied Health Professional: AHP

Activities of Daily Living: ADLs

Community Care Assessment: CC1

Community Health Partnership: CHP

Community Psychiatric Nurse: CPN

Department of Health: DoH

Department of Social Services: DSS

General Practitioner: GP

Gold Standard Group: GSG

Mid Stream Specimen of Urine: MSSU

Mini Mental State Exam: MMSE

National Health Service: NHS

National Health Service Management Executive: NHSME

Occupational Therapist: O.T

Paragraph: para

Single Shared Assessment: SSA

Social Services Inspectorate: SSI

Social Work: SW

Vignette Development Group: VDG



# **CHAPTER 1**

## **1 POSITIONING THE RESEARCH IN A WIDER CONTEXT**

### **1.1 Introduction**

Following the NHS and Community Care Act (1990), the principle of needs-led assessment was reinforced as a key element of the assessment and care management process. Translation of needs-led assessment into practice in Scotland has been further influenced by policy based organisational change such as the introduction of SSA and CHPs.

Assessment of need, and the delivery of care in the form of resources, comprise two components of a decision-making process influenced by external and internal factors. This study sought to: describe the political and practical landscape within which needs-led assessment exists; identify and explore the external and internal factors which influence needs-led assessment and subsequent resource access; consider professional perceptions and decision-making activity in relation to these factors; and explore the practice implications of this policy driver.

In order to achieve the above, the author undertook several forms of information gathering including a comprehensive review of literature, attendance at relevant learning networks and conferences and discussions with other interested individuals / parties. Before considering the content of the literature review, a brief overview of the process undertaken to gather this information is provided.

#### **1.1.1 Review of Literature and other Relevant Information**

Literature was first collected using databases including CINAHL, ASSIA, EMBASE, Medline, SWETWISE and the Social Sciences Citation Index. Terms such as 'needs-led', 'assessment', 'resource-driven', were used as keywords however initially this yielded few relevant references. The terms

used encompassed many practices in health and social care and were often too wide in scope. Several journals specialising in joint working such as 'Health and Social Care in the Community' and the 'Journal of Interprofessional Care' were frequently cited therefore the author undertook specific searches of these journals using key terms. This process, although refined, produced a greater number of relevant articles. All articles and books considered relevant were then scrutinised further to ensure their significance to the research topic. The information provided by each was included in the literature review and influenced the study methodology.

The author found that many articles referenced key papers which had not appeared in any of the database searches undertaken. As a result the author also undertook a manual search of literature and ensured that every article's reference list was examined and new, potentially useful articles identified. As a result the literature available on the research subject increased exponentially. The author then had to define the criteria for inclusion within the literature review, bearing in mind the wider areas covered by other, less directly applicable papers. Relevant policy papers were also examined and included within the review.

During the period of study, the area of joint working and in particular Single Shared Assessment (SSA) was developing as was academic interest in the field. Some small studies were underway and the author contacted several study coordinators / authors to share knowledge and information on the subject area. In particular several research students were identified whose interest in this field had led to the production of PhDs and MScs. These were made available to the author who included the information in the literature review.

Wider knowledge was also obtained through attending national conferences and learning networks around the country, whose main focus was on inter-agency working. In particular the Scottish Executive led, Integrated Learning Networks provided invaluable insights into the reality of converting policy into practice.

During the course of the study, the author followed progress of information and literature through the constant updating of journal references (including conference and newspaper references), policy papers and attendance at national events and informal networks. This, it was believed, provided an holistic, realistic and comprehensive view of the research area and served as a useful mechanism to undertake a review of literature. It was the author's belief that, given the multiple components of assessment, identification of need and practitioner's ability to address need, simple database searches would prove too narrow in focus. A wider approach was required in order to capture all the possible elements involved and influential in the needs assessment process.

### **1.1.2 Background to the Study – Policy Drivers**

The last two decades have been witness to dramatic changes in the description, organisation and delivery of care in the community. Those challenges envisaged by Sir Roy Griffiths in his report in 1988 (Community Care: Agenda for Action) have become a reality for clients, carers, practitioners and policy makers as each seek to accommodate the shift from institutional to community-based care. Devolution of the "market place" philosophy from policy to practice has not proved an effortless procedure and has been paralleled by similar challenges in the development and delivery of both health and social care services. The responsibility to plan and purchase care for individuals and communities has led to both disciplines developing rigorous assessment procedures which attempt to reflect the real needs of those assessed. As both organisations attempt to purchase services which adequately meet the needs identified, the purchaser/provider split, alongside greater consumer participation in the assessment process, has been marketed as the way ahead. This, it is argued, will ensure quality and choice within a mixed economy of service provision.

The assessment of need is a concept central to community care policy and practice. With the emphasis on quality and choice there has been a shift in thinking to facilitate user and carer involvement in the assessment and

planning stages. This is facilitated by the policy imperative of 'needs-led assessment': a concept which will be explored in later chapters. Translation of needs-led assessment into practice has raised several areas of contention, mainly in relation to interpretation. These include: lack of a consensus definition regarding 'needs' and 'assessment'; lack of clarity concerning the purpose and perceived promise of a needs-led assessment; and conceptual and operational inconsistencies between disciplines who assess needs and plan services in the community.

The White Paper, 'Caring for People' (1989) which preceded the NHS and Community Care Act (1990), described proper assessment of need and good case management as the cornerstone of high quality care. When published, the NHS and Community Care Act (1990) was intended to herald a new era for community care in the UK with needs-led assessment and care management central to the government's commitment to improve care for older people. For social services this created a care management system that transferred responsibility for the overall coordination of care for older people to a care manager predominantly within social work. Health staff were therefore required to refer patients with 'social' components of need to social work care managers with the responsibility to address and coordinate the response to need. Despite this apparent differentiation, the NHS and Community Care Act (1990) incorporated the concept of partnership working. Meanwhile within the NHS, the White Paper, 'Designed to Care', published in 1997, introduced the need for evidence-based practice to ensure that care provided was effective, efficient and relevant to improving the health of the nation. In this White Paper, the importance of primary care services was endorsed as was a strong commitment to supporting older people at home and in community settings in partnership with other agencies. Practice-based interpretation and delivery of these policies was subject to conceptual contradictions, which will be pursued in the course of the study, as potentially conflicting philosophies and priorities emerged.

During the data collection component of the study several significant political events and policies emerged within Scotland which not only

affected the assessment and delivery of care, but caused a refocus by practitioners and operational managers on the role and purpose of needs-led assessment. In order to contextualise the study data collection, it is considered worthwhile to present the political landscape as it was experienced by study participants. The remainder of this section aims to provide that overview.

Since the devolution of Scotland from Westminster in 1997, 'Modernising Community Care: An Action plan' (1998) highlighted the need for greater collaboration, with the availability of financial incentives, where movement towards integration could be evidenced. Subsequently the report, 'Community Care: A Joint Future' (2000), was published by the Joint Future Group. This focused on the need for greater partnership working, quicker and more effective access to resources and, in particular, the development and implementation of a Single Shared Assessment for use across community-based disciplines. In 2002, the 'Community Care and Health (Scotland) Act' took forward a number of the Scottish Executive's recent policy commitments including issues related to long-term care, free personal care, joint working and informal carers. Subsequently 'Better Outcomes for Older People' was published in 2005 and underpinned partnership working recommendations with key principles aimed at person-centred care, outcome focused interventions and whole system working for health, housing and social care services.

Partnership working has since consistently pervaded Scottish policy. Examples include the publication of the White Paper creating Community Health Partnerships (Planning for Care – Scotland's Health White Paper, 2003), the Local Government in Scotland Act (2003) which called for the creation of Community Planning Partnerships, and 'Building a Health Service Fit for the Future' (2005), each of which emphasise the need to invest in sustainable community-based services which work strategically and practically with people and not for them. Similarly the White Paper, 'Delivering for Health' (2005) reinvigorated the commitment to reduce the health gap in Scotland, manage more effectively, planned and unscheduled hospital care, and establish new health and social care

services in communities. In addition one of the key recommendations from the Report of the 21<sup>st</sup> Century Social Work Review, 'Changing Lives' (2006), was for care services to work more closely with other universal providers in all sectors in order to find new ways to design and deliver services across the public sector.

At the very heart of partnership working is what is frequently referred to as the 'common currency' of professional language which is most often attributed to the assessment of need. Language and professional culture related to the collection, recording and reporting of needs form the basis of daily interactions between professionals and clients as well as other professionals. Frontline partnership working provides significant contribution to partnership success. Needs-led assessment has consistently appeared within legislation as the vehicle through which needs are identified and subsequently addressed for individuals and communities. The requirement for organisations to work effectively in partnership, or as an integrated service, has caused a re-evaluation of shared concepts of need and assessment, alongside the rationale for community care. In order to consider needs-led assessment in the context of practice, further consideration of the elements which contextualise the unique and shared understanding of common terms as they are applied by professionals, is required.

#### **1.1.2.1 Background to the Study – Personal Perceptions**

At the time of the study the author was employed as a Dementia Care Coordinator with multi-agency responsibility for assessment, resource access and care management. It was witnessing the daily dichotomy faced by practitioners who attempted to undertake needs-led assessments within resource constrained organisations that the inspiration for this study emerged. The author observed and experienced the professional and at times personal dilemmas faced when the needs of individuals were considered in relation to the needs of the wider community. Simultaneously the consideration of need as an entity in itself proved a difficult concept to operationalise. The separation of 'need with'

from the 'need for' required a conscious and deliberate attempt to avoid thinking in terms of resources as opposed to needs.

Having reviewed the literature surrounding the topic, the author decided to attempt to deconstruct the components which constituted an assessment of need: the factors which influenced meeting those needs: and the stages within needs-led assessment decision making and potential professional differences. It was perceived that an understanding of these elements would contribute to the debate concerning the practical reality of implementing needs-led assessment within professional organisations and policy frameworks.

Professional experience of needs led assessment, as practiced within health and social care services, led the author to identify several generalised, perceived differences:

- Social workers appeared more concerned about exercising a needs-led approach to assessment despite being more aware of resource constraints.
- Nurses appeared to undertake assessments based upon knowledge of clinical expertise whereas social workers often set aside professional 'expertise' and used their communication skills to perceive the world from the client perspective. Social work assessments were therefore considered to be more client than professionally driven.
- Nurses appeared to acknowledge their own resource constraints but where responsibility to address need rested with another organisation the limitations of resource constraints were minimised and a clear expectation that, following referral, needs would be met was apparent (regardless of the resource constraints faced by the other organisation).
- Assessment and care planning / implementation were regarded by many health and social care workers as one and the same process.

- Needs were often expressed by health and social care staff as outcomes i.e. a need for a particular resource as opposed to a need with a particular component of daily living.

It was the author's personal belief that assessment, care planning, implementation and evaluation were four distinct components of the same process and as such should be treated independently. In order for assessment to be needs-led, the author believed this should be separated from care planning activity which could then legitimately be resource driven.

The above were all assumptions that the author carried into the study: indeed these beliefs motivated more in depth consideration of the area and facilitated the decision to identify the practice of needs-led assessment as the study topic. The perceived differences between health and social care workers stemmed from the author's daily experience of discipline specific assessment: this had the potential to influence the study process, methodology and outcomes. Similarly as the author practiced separation of assessment of need from the planning of care, there was an assumption that this was common practice. At the beginning of the study, the author therefore had to identify and acknowledge these assumptions as potential influencers which, as well as informing the study methodology, could bias study results. For this reason every effort was made to set aside personal beliefs and values, and undertake a study which considered literature and practice as neutrally as possible.

### **1.1.3 Language - Professional Perceptions and Definitions**

Community care policy acknowledges the requirement for inter-agency collaboration at all levels from identification of need, to response by resources. The professional structure and organisation of health and social care organisations varies not only in theory but also in practice. Differences in orientation, purpose, training, language and professional values, diversify interpretation of needs and outcomes between the two disciplines. This is particularly evident in the area of needs-led



assessment. A corporate definition of need and a shared understanding of the role of assessment appear elusive in literature, making various interpretations possible (Harding et al. 1987, Lightfoot 1995, Nolan and Caldock 1996).

Adhering to a needs-led approach to assessment requires the consideration of professional philosophy, policy, and practice and should reflect the perceptions and interpretations of assessment and care in the community as it is understood and applied by those professionals who practise it and those clients who receive it. Indeed 'Caring for People: Community Care in the Next Decade and Beyond' (Department of Health, 1989) states that the user and the carer should together and in partnership with the assessor determine the need for care and services.

#### **1.1.4 Collaborative, Consistent Working - Prerequisites for Shared Understanding**

According to McWalter et al. (1994), multidisciplinary working demands shared understanding of common concepts to ensure clear and accurate communication and a common comprehension of practice. In practice health and social care services provide the majority of community care yet research suggests that there is little or no shared definition of need or locally agreed outcomes (Twigg and Atkin 1994).

The implementation of collaborative working between agencies requires a shared understanding of common concepts. This is particularly evident amongst clients with complex or rapidly changing needs such as those with learning disabilities, older people and those with mental health problems.

#### **1.1.5 Premise and Purpose of the Study**

"Get the assessment wrong and axiomatically what follows is compromised" (Nolan and Caldock 1996 p77)

Despite the fundamental importance of the needs assessment process, there exists little clarity or consensus regarding definitions. It is the purpose of this study to investigate the definitions of need and assessment as applied by professional groups (mainly health and social care) within the context of community care for those with dementia. It will include consideration of how terms are expressed and understood at a theoretical, policy and practical level and will explore the challenges, opportunities and realities of needs-led assessment as it is understood and undertaken in practice. Exploration of the factors which impinge on this process will expose the practical implications of operationalising needs-led assessment and present a picture of practice as it currently stands for both health and social settings.

## **1.2 Need: Common Concepts and Definitions**

Needs-led assessment within community care is based upon the premise that 'need' and 'assessment' are interpreted universally within vocabulary that spans policy and practice. A review of literature quickly highlights the inconsistencies in definition and application. This chapter aims to explore the most commonly cited definitions and interpretations of the concepts of 'need', 'assessment' and 'needs-led assessment', and seeks to apply the understanding to the implications of practising needs-led assessment.

Whilst negotiating the intricacies of this area, Lightfoot (1995) identified three dimensions to the definition of need, viz. theory, policy, and practice. Without basic knowledge of the fundamental concept of need, a proper appreciation of the implications for policy and practice is compromised. Lightfoot proposes that a clear understanding of need in conceptual terms is a prerequisite for developing welfare policy and practice. While the term has become ubiquitous in our vocabulary, little consensus exists over a definition: an issue that unless resolved will prove to be more ambiguous. Embarking on such a mission is not, suggests Culyer (1976) without its dangers. He describes the field as "treacherous territory" (Culyer 1976 p17). Smith (1980) cautions that all too often the

"strategy is to note the problems of definition and usage but continues nevertheless regardless of them" (Smith 1980 p41).

Many definitions of need exist apparently undisputed in our vocabulary. Deconstructing these definitions exposes professional paradigms, which are often at the root of professional identity. Therefore examination of the concept of need and its application may expose professional values and predispositions. Timms (1977) notes that consideration of need usually acknowledges the existence of complexity, even though as far as social work is concerned, discussion is often "launched in the absence of any deep sense of puzzlement about the concept" (p37).

### **1.2.1 The Context of Defining Need**

Many attempts at defining need tend to be based on its assessment rather than the concept of need itself. Within the realm of community care, needs are rarely discussed outwith the context of 'need meeting activity'. Needs are frequently described as the 'need for' as opposed to the need associated with an area subject to context and individualisation. In practical terms this complicates the process of needs-led assessment as practitioners lack terminology that is not service based. Rein (1969) commenting on needs research concluded that:

"This type of research attempted to identify the disparity between needs and resources where resources were defined with reference to the established pattern of professional services and community facilities. Not surprisingly, with unfailing regularity these studies concluded that there was a need for whatever community service was the focus of their inquiry. Such studies were mired in a conceptual confusion from which they could not be rescued" (Rein 1969 p174)

Magi and Allander (1981) use the example of need statements to illustrate the point that many of these imply change and a means to an end. For example to say that someone has a medical need implies that

they are in a state of bad health, amenable to change by medical intervention i.e. 'medical needs' implies 'need for medical services'. Nevertheless the point is made that many need statements cannot be given an instrumental interpretation since what is needed in many cases is not a means to an end but a part of an end in itself.

### **1.2.2 Need within a Hierarchical Context**

Maslow (1968) proposed a hierarchical approach to the definition of human need, discriminating between needs which are mandatory to basic human survival and those that are discretionary i.e. those relating to quality of life terms. In the 1940s, Beveridge viewed need in physical terms, as a static concept, by establishing a minimum, or subsistence level that would meet the individual's basic need for survival. Doyal and Gough (1991) describe a minimum set of basic needs which society must commit to satisfy in full, beyond which there is a second stage of optimum need satisfaction. This supports the notion of a threshold or measurement of need that is essential as well as one that is desirable.

There are therefore difficulties associated with the definition and construction of need theories. The hierarchical approach to need theory is often criticised as untenable and rejected in favour of a less technical and more fluid approach. Jones et al. (1983) suggests that the hierarchical approach is too rigid and simplistic. Alternatively, need is considered as socially constructed involving the wider social context and incorporating attitudes and values of individuals. Similarly Harding et al. (1987) highlight the complex nature of contemporary needs as applied to client groups. They call for a retreat from the notion of 'specific aetiology' towards one of 'multiple causation': addressing the inter-relational aspects of needs including those basic or general to human functioning and those considered special. Wing (1986), in relation to mental health, defined needs as the consequences of social disablement: i.e. physical, social, and psychological functioning that is lower than ordinary societal expectations. Commenting on the social and biological constructs involved in need, Fagnani and Dumenil (1976) assert that need be defined as the

product of the interaction between physiological necessity and existing socio-economic order.

Within both health and social care, external and sociological constructs are basic to both the practical definition and assessment of need. Identification of those constructs, whether specific to individual need or more general, reflecting corporate need, often forms the basis of universally accepted definitions of need. The result is a definition of need based largely on the process of identification, assessment and/or measurement. Bonuck (1996) describes a preoccupation within social work to measure need rather than discover its causes. This, she argues limits the ability of practitioners to guide ameliorative action.

Cowley et al. (1995) describe need as a dual concept which incorporates precise and objective aspects as well as those subjective and dependent on individuals' perceptions. As such needs can be variable, personal, subjective and immensely changeable according to context: making identification, assessment, measurement or classification difficult. Alternatively, needs can be far from covert; they can be amenable to precise specification and sometimes measurement. While these two elements seem contradictory or even conflicting, Cowley et al. (1995) argue the point that any assessment would be incomplete unless it encompasses both.

An example of the above is evident in Bradshaw's Taxonomy of social need. In 1972, Bradshaw first introduced a concept of need that has as its base a broad-spectrum approach to definition and identification. Bradshaw described the concept of 'social need', defining terms in relation to personal, inter-personal and environmental factors, some of which are measurable, others less so. Futter and Penhale (1996) describe the notion of taxonomy as useful in describing how need is defined by different individuals but attention is also drawn to the fact that it provides little to explain the derivation of need. Bradshaw favours taxonomy of need and describes four separate definitions within the context of social need:

'Normative' need is the 'desirable standard' set down by professionals against which existing standards are compared. Individuals who fall below that standard are considered to be in need (McWalter et al. 1994). Normative needs are generally quantifiable but are subject to change as culture and expertise vary with time. Professionally defined need in health care is usually measured by standards laid down by health professionals and is normally derived from data about the nature, extent and severity of health problems (Hamid et al. 1995).

'Felt' or 'perceived' need is often equated with 'want' and 'demand', and is limited to the perceptions of the individual. It is considered an inadequate measure of real need, and may be over or underestimated. Similarly individuals may think in terms of existing interventions (or resources) which would compromise the expression of need. McWalter et al. (1994) stress the point that certain individuals are unable, for various reasons, to accurately perceive or articulate need. This is clearly evident in the case of dementia. Similarly a person's expectation and perception of their rights and needs may vary with time. Establishing the reliability of an assessment of need based largely on a perceived definition of the same proves problematic.

'Expressed' need is traditionally described as felt need in action, or evidence of demand. Similarly demand has been described as 'want' translated into action (Hamid et al. 1995). Health and social services' waiting lists are taken as a measure of unmet need and as such are examples of expressed need.

'Comparative' need is depicted as a measure by studying the characteristics of those already in receipt of a service. Where two similar populations have access to a particular service, the population not in receipt of the service is considered to be in need.

The latter two definitions concern populations and are limited to the scope of existing service provision. McWalter et al. (1994) acknowledge that need is a relative concept, implying elements of both factual information

and value judgements. While Bradshaw's model is a useful conceptual description of need, it demonstrates the absence of any absolute measure of need. Classification of need in the context of how it is assessed constitutes many commonly accepted definitions.

### **1.2.3 The Perceived Homogeneity of Need and Social Constructs**

McWalter et al. (1994), like Cowley et al. (1995), argue that any needs assessment, if it is to be both reliable and valid, must be based largely on a normative definition of need. Slade (1994) suggests that this is the approach underlying attempts to formally assess need. He suggests that most tools employ expert or professional perception as the main basis for assessment of need. Here the point is made regarding the socially negotiated nature of need and suggests that what is considered a need to one person may not constitute a need to another. The users' view, he argues, will be filtered through their particular sociocultural context, and will be tempered by their expectations and past experiences. On the other hand, staff perspective will be informed by the values of the British caring professions, and will be influenced by their training and personal experiences (Slade 1994).

This, it has been argued, constrains the way in which the research of definitions of need is conceptualised. It suggests it is a relatively static and measurable property of particular individuals. According to Smith (1980), this is consistent with traditional notions of need. "The hallmark of this tradition", he argues, "is that it has undertaken the search for universal criteria of need, criteria to be used commonly by professional practitioners, administrators, clients and researchers alike" (Smith 1980 p65). This is based on several assumptions including the notions that need: is an unambiguous and objective phenomenon, is an attribute of the client or potential client, is a property of an individual conducive to measurement and is essentially a static phenomenon. The failure to adequately conceptualise, measure and evaluate need appears consistently in needs research literature. Smith (1980) concludes that:

“Neither minor modifications to the traditional approach nor further research investigation along similar lines is likely to resolve those problems, which are endemic to that tradition of research. What is required is a theoretical *reformulation* of these central problems” (Smith 1980 p67)

Smith (1980) proceeds to introduce an alternative approach to social need, which differs from traditional models on four counts:

- Need is viewed as socially constructed reality, as the objectification of subjective phenomena. Therefore it is closely dependent on the concepts of professional practitioners.
- The central topic of enquiry is the way in which needs are practically managed. Need is viewed as closely dependent on organised professional practices which routinely establish its definition and nature.
- Need is viewed as situated. Attention focuses upon the context of need.
- A distinction is drawn between topic and resource. Need is viewed as a research topic and as a welfare professional’s resource.

To elaborate Smith (1980) highlights the argument that ultimately, reality is socially and subjectively constructed. Kempshall (1986) elucidates the meaning of the concept by arguing that need is principally determined by the social context within which it exists: as such it is a socially constructed phenomenon. This challenges the opportunity for objectivity and the process whereby subjective meanings become facts. Applied to the concept of social need, it is difficult to define need objectively without acknowledging the concepts and precepts of professional practitioners, who in the main are concerned with the process of meeting need. This then begs the question of how in practice are needs defined or identified? That is, how does the process of objectification occur? Fundamental to consideration of this question is the context within which need is identified including those factors, which converge to create context. These may include time, place, and assumptions (both personal and professional).



The potential to successfully implement needs-led assessment in practice therefore comes into question.

### **1.3 The Concept of Need and Need Management in Practice**

Smith (1980) cautions against making the mistake of defining need for research purposes, which does not take into account the practical realities of its application. As a consequence Smith regards social need alternatively and attempts to avoid, rather than resolve some of the difficulties commonly encountered. Social need is therefore not considered clearly defined, is highly ambiguous, and closely dependent upon concepts and theoretical models.

Rather than being viewed as an attribute of an individual, need is considered as the property of organisational milieu employed in different ways and situations, by different personnel to different effect. As a result need can only be measurable as a dynamic process, through fieldwork observation of service delivery within an organisational context. The conceptual strategy adopted by Smith (1980) involves the consideration of social need within three general domains. These are: the unit of need i.e. the individual client or family; the causes of need identified and interpreted through therapeutic relationships within casework practice; and the assessor of need including professional values. Slade (1994) reinforces the complexity by describing the socially negotiated nature of need, which is subject to the passage of time.

Brewin et al. (1987) consider some of the theoretical and practical connotations of the term 'need'. Dictionary definitions indicate a range including: a state of want or destitution, a condition requiring some extraneous aid, and an imperative call or demand for some provision. In response to the confusion, Brewin et al. (1987) recommend that users of the term need should be clear about the extent to which they are simply identifying a problem, recommending a likely course of action, or making an imperative claim about the avoidance of harm to the person.

Other authors use the term need to describe deficits in functioning without stating whether action is necessary or likely to be effective (Falloon and Marshall 1983). Others make explicit references to particular types of intervention (Wykes et al. 1982). Magi and Allander (1981) point out that when describing need, statements imply both factual and value elements. That is to say, need statements may describe an actual state of affairs, but they also depend on an implicit or explicit value system that determines which states of affairs are considered acceptable and which courses of action are considered appropriate. Slade (1994) asserts that underlying attempts to formally assess need is the assumption that needs can be reliably and validly measured. Within health care this is reflected in the design of most assessment recording tools, which use professional perception as the main basis for assessment. Brewin et al. (1987), like Smith (1980) acknowledge that:

“Need, then can never be objectively defined, but must be understood in terms of the person or group making the judgement”  
(Brewin et al. 1987 p972)

Consideration of need in every day practice requires acknowledgement of the complexities associated with the term. Twigg and Atkin (1994) identify the need for greater specificity of terms but McWalter et al. (1994) warn against replacing one vague concept with a set of others. Culyer (1995) considers some of the characteristics of a working definition of need which are necessary if the term is to be applied universally. Within the realms of health care, Culyer proposes the following conditions should be applied to the definition of need:

- That it is directly derived from the objectives of the health care system
- That it is capable of empirical application
- That it should be service and person specific
- That it should enable a straightforward link to be made with resources
- That it should not produce manifestly inequitable results

Culyer (1995) suggests one definition of need that nearly meets these criteria is 'capacity to benefit'. This consideration introduces external factors which impact on unmet need and impinge on the individual's capacity to benefit by particular interventions. Determination of capacity to benefit involves some form of assessment or measurement. In relation to health service planning, Stevens and Gabbay (1991) describe need as the ability to benefit in some way from health care. Phelan et al. (1995) expand this definition, when applied to severe mental illness, to include social care as well as health care. Doyal and Gough (1991) suggest that the universal need for physical good health and individual autonomy are the essential prerequisites for active participation in social life by individuals.

#### **1.4 The Definition of Need in Health and Social Care**

Policy guidance for both health and social care defines need as the capacity to benefit from care. Traditional definitions of need as presented above describe its contextual basis, often in relation to social constructs. The relationship between health and social need is rarely disputed in literature although some studies suggest a distinction between medically and socially defined need (Davies and Challis 1986, Ong 1991, Billings and Cowley 1995, Ong 1995, Bonuck 1996, Worth 1996, Waterson 1999, Parrott 2002,). It is the intention of this section to consider general constructs of need, highlight those needs attributable directly to health or social care and consider the perceptual implications.

Lightfoot (1995) asserts that for the NHS, the emphasis is on health gain so the definition of need depends upon the definition of 'health'. Health, it is argued, is narrowly defined within policy as a traditional medical model. Lightfoot argues that as a result, the approach towards needs-led assessment is characterised by a focus on disease and is seen in the context of existing service delivery. Rolland (1988) argues that chronic conditions tend to be viewed as homogenous, creating basically similar demands throughout their course. He argues the reality is very different, and presents an approach that provides practitioners and researchers with

a better understanding of the impact of disability on the biological and psychosocial worlds of sufferers and carers. Richards (1994) suggests that despite their diversity, older people are perceived as a relatively homogenous group in respect to their needs. Similarly old age is frequently associated with needs relating to dependency. One definition states that:

“Needs are said to show a requirement for individuals to enable them to achieve maintain or restore a respectable level of social independence and quality of life, as defined by the particular care agency or authority” (SSI 1991, para 11)

Nolan and Caldock (1996) highlight concerns over this definition that has as its focus a professional/normative approach to the definition of need. This, they argue, disempowers users and carers whose contributions appear to be marginalised. Waterson (1999) extends these concerns when considering the risk aversion culture that appears to pervade community care: the argument is made that practitioners are increasingly required to undertake a risk-led, as opposed to a needs-led approach to assessment, further disabling both practitioners and clients. Reasons suggested for risk-led assessments are: an increased requirement to manage risk, relate need to thresholds of risk, and contain scarce resources.

#### **1.4.1 Need as Defined by Professional Assessment**

When considering definitions, the separation of need from its assessment becomes increasingly difficult. Literature rarely considers need as a unique entity instead it is frequently described alongside models of assessment. Often descriptions of need are the result of the application of an assessment process. Indeed need is commonly described in relation to assessment, either individually or collectively (e.g. as part of a community or population profile). Clarke (1990) illustrates the significance of terminology in a nursing context and asks, ‘is nursing a problem-solving activity or needs-meeting activity?’

The Nursing Process (Yura and Walsh 1988) was introduced initially as a problem-solving approach, whereby a problem is deemed to exist when clients, for some reason cannot meet their needs. The negative connotations associated with 'problem' terminology detract from the holistic, enabling and individualised approach originally intended. The conclusion drawn by Clarke (1990) suggests that a shift in emphasis from 'problems' to 'needs' will help redress the balance. Needs in nursing and medical care usually emerge in relation to illness, disease, trauma or other health related life events with a focus on prevention, treatment or some form of management. Commenting on nursing models of care, Ong (1991) describes how the basis for decision-making is the professional assessment of the client's needs, embedded in the logic of nursing. These concepts, it is argued, are derived from the medical model's focus on the disease: a medical/scientific entity. This is qualitatively different from illness, which is the experience of both a biological and social event. Illness, in this sense, is perceived to be socially constructed. An individual has to acknowledge subjectively that he or she feels unwell, and this has to be confirmed by others such as professionals or social networks (Ong 1991). Therefore the following point is made:

"Within the context of nursing, the possible discrepancy between the professional's definition of need and that of the client has to be understood in the light of the opposition between disease and illness. The implications for the assessment of need are obvious: needs have to be defined in a co-operative manner, resulting from a dialogue between professionals and clients (p639). If district nurses are serious about understanding people's needs, they have to acknowledge that these needs are socially constructed and closely bound up with identities and expectations" (Ong 1991 p644)

Twigg et al. (1990) however, highlighted that holistic assessment is the dominant approach in modern nursing. Many nursing models of care focus on the whole person, or the person and their social environment. Thus said, practical difficulties emerge with this approach when translated into care plans and resource interventions. The White Paper 'Caring for People'

(DoH and Social Security 1989) distinguishes between social and health needs. This distinction is artificially drawn, argues Ong (1991), who considers it unhelpful in the process of identifying need, particularly when each is considered the responsibility of different agencies. Caldock (1996) discusses the social and medical models of care and challenges the often automatic and inappropriate application of the medical model suggesting that:

“The primacy of the medical model over social models may lead to an unbalanced focus upon illness, dependency and risk, rather than permitting the proper assessment of an individual’s determination to adapt, cope, take risks and make choices” (Phillips and Penhale 1996 p31)

Nolan and Caldock (1996) also highlight the differences between and within professions where assessment of need is deeply rooted in their professional training, identity and culture. In the absence of a clear professional definition of need that is mutually understood, responses to need will vary within and between professions.

Lightfoot (1995) suggests that the health economist’s approach to defining needs challenges the hierarchical perspective. Their view of need requires the formulation of judgements with particular reference to health care. The recommendation is made to remove reliance upon the ‘implicit, incoherent and inconsistent’, process of decision-making by medical experts (Maynard 1990). Lightfoot (1995) describes the health economist’s view of medical experts as being more concerned with service delivery than with need. As a result there is an over-concentration on the end rather than the means which is, it is argued, illogical given the instrumental nature of the concept of need.

Nevertheless, Hostick (1995) interprets mental health needs in terms of service outcomes or interventions and adopts a broad notion of need. Here needs are defined as services that are deemed necessary to benefit mental health as opposed to services to treat mental illness. Similarly

Slade (1994) describes some of the theoretical perspectives of definitions of need. Psychological theories have used the concept of need as a basis for understanding action. Psychiatry by contrast often employs the constructs to inform service provision and plan individuals' care.

The DoH/SSI (1993) identified two main models for assessment: the questioning and the exchange model. The questioning model assumes the assessor as the expert in identifying need and selecting the means by which these are managed and/or resources allocated. A study by Badger et al. (1988) suggests that district nurses rarely consider the client's perspectives in determining appropriate care. They argue that nurses tend to view people in isolation from their social situations and suggest that the perceived expert status of the health professional causes patients to allow nurses' perspectives to prevail. It concludes that the dominance of nurses' daily routines makes the service inflexible to the changing needs of the individuals it serves.

The exchange model assumes the patient/client, carer, significant others as well as the professional each have equally valid perceptions of the needs in question and that each contributes to the assessment and suggested outcomes. The exchange model reflects the framework supported in social care policy guidance,

"Instead of users and carers being subordinate to the wishes of service providers, the role will be progressively adjusted. In this way users and carers will be enabled to exercise the same power as consumers of other services. This redressing of the balance of power is the best guarantee of continuing improvement in the quality of service" (SSI 1991a p11)

## **1.5 Practical Applications of Definitions of Need in Health and Social Care**

The theory or law of effect is often applied to the concept of need; that is, a need does not exist in a vacuum but is understood as a need for something. That 'something' implies an ultimate end state, that the act of need satisfaction will achieve (Lightfoot 1995). Clarity of description regarding the end state is considered by some as a necessary element in the definition of need. However this interpretation assumes an end state that is universally attainable and acceptable. Many studies contest this view, demonstrating differences in the way in which professionals and individuals conceptualise need. Richards (1994) considers the concept of need as one of eligibility defined by policy makers and then operationalised by those responsible for rationing and targeting agency resources: that is, needs for which services should be provided:

“In the context of community care, need has to be defined at the local level. That definition sets limits to the discretion of practitioners in accessing resources. Consequently, there is an onus on elected members and board members to revise the policy framework within which managers and practitioners are asked to operate. A needs-led approach requires needs to be explicitly defined and prioritised in policy statements” (DoH/SSI 1991a Care Management and Assessment Practitioners Guide p12)

Where 'need' is considered as a means to an end, focus on the outcome as well as the process helps to maintain definitions in tangible terms. For instance an individual may be assessed as having a need for physical assistance with bathing. Specification of intervention apart from service delivery maintains definitions within terms, which describe need and not need for a particular service (McWalter et al. 1998). Difficulties emerge when there are several interventions, which may fully or partially meet a need. The result, argues Slade (1994) is that the use of the term 'need' can reduce the extent to which assessment is needs-led, since



intervention effectiveness rather than need is being assessed. At the extreme, Culyer warns that, one of the principal dangers of the language of 'need':

"is that it encourages a particular form of sloppy thinking, namely denial of substitutability of alternative means in attaining an end" (Culyer 1976 p14)

Bonuck (1996) explores professional approaches to unmet needs with a particular focus on social care. Due to their particular skills, training and expertise, social workers are considered more holistic in their thinking about interventions. Their awareness of the social, cultural and physical environments in which people become ill then seek care and support, encourages their use of a range of possible interventions. Similarly, the expectation that needs can be investigated and causes of unmet need identified and addressed where appropriate, is also considered a defining element.

Magi and Allander (1981) assert that in the planning process the formulation of priorities is the most important step, influencing the subsequent measures that will be taken. The question is thus asked, "how should need, then used as a guiding principle for the allocation of resources, be related to other principles such as equity, efficiency and objectivity?" (Knox 1978). Knox suggests that these principles conflict with each other. The principle of need has its priority at the individual level with equity at the centre. At the intermediate levels the main concerns are efficiency, effectiveness and maintenance of standards. Issues arise in achieving accommodation between the constraints of equity (top down) and of assessments of need (bottom up). In practice Lightfoot (1995) asserts that policy cannot be wholly divorced from means i.e. decisions about resource allocation and practical delivery, and asks, "is need a useful concept for thinking about allocating resources in health and social care?" Smith (1980) argues that, all things considered it is not, because the concept of need has been made to work too hard in policy, practice and research.

## **1.6 Chapter Conclusions**

The concept, definition and practical application of need has created an industry of theories and models which have been identified within this chapter. Need is regarded rarely as a single entity and is most often described in relation to its cause, effect, action required or assessment. The perceptions of those defining need in general or at an individual level add to the complexity of thinking around its definition, to the extent that some authors are provoked to 'banishing' the term completely.

In the context of needs-led assessment, perceptions and definitions of need form the basis upon which assessment is considered. Assessment of need relies heavily on underlying principles, and as such Chapter Two considers the literature concerning assessment as it applies to need. This facilitates the consideration of 'needs-led assessment' within this study as an overarching concept laden with the complexities surrounding need and assessment.

## **CHAPTER TWO**

### **2 THE ASSESSMENT AND/OR IDENTIFICATION OF NEED**

#### **2.1 Chapter Introduction**

It is the purpose of this chapter to consider assessment as it is conceptualised and defined in policy and practice. Consideration of assessment often involves the perception of need applied to particular descriptions therefore few definitions are devoid of the language of need. This chapter aims to consider assessment as it is understood in definitive terms and will explore some of the perceived professional nuances which accompany it.

In order to achieve these goals, this chapter considers philosophical, policy and practice based definitions of assessment and reiterates the difficulty in decoupling assessment from definitions of need. Several approaches and models of assessment will be considered although these are used only as examples and are not an exhaustive account of the many variances which exist. The traditional 'health versus social model of care and assessment' is considered, although references are at times ambiguous within literature. The implications for needs-led assessment are considered in relation to both the conceptualisation of 'need' and 'assessment'.

#### **2.2 The Value Base of Needs Assessment**

Carter et al. (1995) describe various perspectives and approaches to need and needs assessment. These include sociological, medical and service evaluation. A unifying aspect of each of these approaches is that needs are invariably conceptualised as value judgements whereby a person has a problem which can be solved. Carter et al. (1995) express difficulty with this concept: if need identification and assessment involve value judgements then people with different values will recognise different

needs. This applies to individuals, users, carers and professionals. With this in mind the plea is made that:

“If the assessment of need cannot be value free, and value judgements are considered central to the perception of needs-assessment, then the value judgements involved should be made explicit” (Carter et al. 1995 p387)

Carter et al. (1995) explain that as a consequence it becomes misguided to try to develop value free operational definitions of need and the assessment thereof. This is supported by Brewin et al. (1987) who suggest needs can neither be rational, have their basis in objective reality or be defined along a unidimensional scale.

## **2.3 The Construction of Needs Assessment**

Assessment of need, despite its obvious ambiguities, is a practical reality for community care practitioners, service providers and users. Much literature surrounds the area and suggests that more than one measurement perspective is required and applied (Yura 1986, Gordon and Spicker 1997, Lasalvia et al. 2000). This, argues Carter et al. (1995), is because need is best identified by a combination of methods with differing outcome expectations. Cook and Campbell (1979) suggest that no single indicator or criterion measures a construct perfectly. Therefore they suggest that multiple indicators of need are more likely than single indicators to present an accurate measurement of a construct.

Consequently Carter et al. (1995) consider the question as to whether an assessment of need should be based on a particular conceptual approach to need in general. The argument is supported by the contention that an assessment of need informed by personally and professionally defined needs is more likely to reflect true needs than one which is informed by a single perspective only. Difficulties emerge with this approach when applied to needs which are neither readily achieved nor measurable if achieved. For instance the need for 'health' is a term used frequently but

does not specify accurately the exact outcome, is vulnerable to subjectivity and as such does not define the need. On the other hand the need for health care is perhaps more conducive to description and is defined as the requirement for preventative, curative and rehabilitative care which arises from disturbance of health as defined by health professionals (Holland 1983).

Hamid et al. (1995) provide a general overview of the assessment of need which makes the distinction between population-based approaches (such as epidemiological studies) and individual needs assessment, the latter being subdivided into 'individual needs assessment' or 'needs for intervention'. A review of literature suggests clear distinctions between the two with little cross fertilisation of approaches, techniques or models.

Brewin et al. (1987) suggests a method for measuring the needs of the long-term mentally ill. This approach involves three concepts. Firstly, that of social disablement, which is measured in terms of lowered physical, psychological and social functioning compared to what would ordinarily be expected in a particular society for a particular individual. The second concept concerns methods of treatment or care that are considered effective and acceptable means of reducing or containing the components of social disablement. The third conceptual level involves the services needed to provide treatment or care to people who are socially disabled. This entire approach, it is argued, relies on the key principle that neither the professional nor the patient is the sole arbiter of the existence of a need and that needs as a consequence must be based on shared goals.

Slade (1994) described needs for improved health using the social disablement aspect of this model i.e. a reduced level of psychological, social and physical functioning. Assessment of social disablement is considered the construct of three categories of social functioning: social attainment, social role performance and instrumental behaviour measures. Social attainment relates to achievements in major life roles such as marriage and employment. Social role performance measures assess performance in major roles such as work, relationships, home and

self care. Slade (1994) suggests that social role performance measures give a more detailed assessment of a person's performance than social attainment measures and are more sensitive to minor disablement in social function. Finally instrumental behaviour measures record detailed descriptions of social behaviour. However Slade (1994) describes that such approaches do not take into account the context in which the behaviour takes place and the scales used depend solely on staff report and professional perceptions. This observation is made by Magi and Allander (1981) whose perception of needs assessment in health care is described as traditionally the determination of need for medical care, based solely on professional judgements. Here the claim is made that:

"The determination of need *should* be a joint concern between the provider and the client (actual and potential) not only in every day clinical practice but also in the planning process" (Magi and Allander 1981 p51)

## **2.4 Consideration of Models to Undertake Needs-led Assessment**

The DoH/SSI (1993) identified two main models for assessment: the questioning and the exchange model. The questioning model assumes the assessor is the expert in identifying need and selecting the means by which these are managed and/or resources allocated. A study by Badger et al. (1988) suggests that district nurses rarely consider the client's perspectives in determining appropriate care. They argue that nurses tend to view people in isolation from their social situations and suggest that the perceived expert status of the health professional causes patients to allow nurses' perspectives to prevail. It concludes that the dominance of nurses' daily routines makes the service inflexible to the changing needs of the individuals it serves.

The exchange model assumes the client, carer, significant others as well as the professional each have equally valid perceptions of the needs in

question and that each contributes to the assessment and suggested outcomes. The exchange model reflects the framework supported in social care policy guidance,

“Instead of users and carers being subordinate to the wishes of service providers, the role will be progressively adjusted. In this way users and carers will be enabled to exercise the same power as consumers of other services. This redressing of the balance of power is the best guarantee of continuing improvement in the quality of service” (SSI 1991a p11)

#### **2.4.1 Professional Power in Assessment**

Briggs (1991) notes the implicit assumption in community care legislation of equality between the client and case manager which considers them as equals doing business together. Futter and Penhale (1996) assert that the assessment of need appears to be viewed as an entirely neutral concept. Briggs argues that this is a naïve assumption asserting that equality cannot be assumed within a helper-helped relationship when one person controls the resources which will effectively meet the needs of the other. There is consequently an inequality in the balance of power between practitioner, user and carer.

Richards (1994) describes the power of statutory workers to grant or deny access to resources and emphasises that the effect of this should not be underestimated. Hasenfield (1992) also reinforces the power social workers exercise over clients due to their specialist knowledge, interpersonal skills and the authority given to them to impose social norms. This is described in more detail by Meethan and Thompson (1993) who refer to the asymmetrical power relationship between professionals and consumers. Several approaches are suggested in order to address this issue including better information sharing, advocacy and carers' assessments. Challenges arise when social workers are required to act as advocates on behalf of the clients whilst at the same time acting within

service constraints and controlling the resources of their own agency (Futter and Penhale 1996).

Smith (1994) argues that for assessments to be truly needs-led, there must be a separation between the assessing practitioners and systems of budgetary control. Futter and Penhale (1996) argue that if practitioners are accountable for budgets they can do nothing but continue to act as gatekeepers, rationing scarce resources. Needs-led assessment which incorporates greater user voice and choice is heralded as the way forward but, as Myers and MacDonald (1996) describe, this does not occur effortlessly. In practice terms it is envisaged that the transfer of power will be achieved through involving users and carers in actively defining their needs through the sharing of assessment recording tools, access to care plans and the facilitation of the choice of options wherever possible. In addition, enabling service users to become empowered consumers discourages dependence, facilitates greater client/carers commitment in realising objectives and, provides the recipients of resources with a sense of control (Myers and MacDonald 1996).

#### **2.4.2 Consumer Power in Assessment**

The empowerment of clients is described by Beresford and Croft (1993) as based on 'exit' or 'voice' strategies. Voice (or democratic) strategies suggest the consumer is able to change the system from within. Similarly, exit (or market) approaches assume the consumer can take his/her custom elsewhere if dissatisfied with a service.

In the context of community care policy, Myers and MacDonald (1996) describe the creation of a quasi market of competition between providers. This places an emphasis on clients' power to 'exit' whilst the involvement of users and carers in service planning suggests an emphasis on 'voice' as a strategy. The extent to which both strategies accomplish client empowerment appears to differ. Arnstein (1969) proposed an eight rung ladder model of citizen participation which ranges from non-participation at the lowest level to citizen control at the highest. Myers and MacDonald



(1996) highlight that for clients and carers to move up the ladder they require both the opportunity to exercise this power and the ability to use it wisely. Myers and MacDonald (1996) assert that,

“On the part of the users and carers, the sense of their own vulnerability, as well as a lack of expertise, may serve to inhibit the exercise of either ‘voice’ or ‘exit’. For users and carers to make their way up the ladder of participation they must first have to circumvent the snakes of resource constraints, professional autonomy and their own sense of powerlessness” (Myers and MacDonald 1996 p94)

Several factors inhibiting the progression up the ladder of participation are suggested: constraints such as choice of services highlight the reality that preference may not be the main criterion. This, Myers and MacDonald (1996) describe, occurs because the reality of a potential service user becoming an actual service user depends on the achievement of defined eligibility criteria. Similarly an unequal spread of resources across areas limits choice to locality and ability to pay. The implementation of charging policies has been described as both empowering and disempowering for clients and carers. Contributing towards caring costs can signify independence and encourage a greater sense of control however inability to meet costs of preferred services may lead to clients refusing services.

Myers and MacDonald (1996) also describe cultural difficulties as placing constraints on clients and carers as consumers of services. The perceived reluctance of clients to be empowered is explained by some as age related. Meethan and Thompson (1993) describe ways in which clients and carers tend to defer to professionals’ opinions, accepting the judgement of those perceived to have expert knowledge whilst recognising their own sense of powerlessness. Ideally, clients seek a care manager,

“who had status, who was able to cope with bureaucracy, had good contacts, was shrewd and assertive (with service providers) and

could generally ensure the prompt and consistent delivery of the required care” (Meethan and Thompson 1993 p16)

## **2.5 Disempowering Components of Needs-led Assessments**

Myers and MacDonald (1996) describe an imbalance in perceived authority not only because of professionals’ knowledge base but due to their power to access resources. Caldock (1994b) argues that terms such as ‘need’ and ‘care’ place clients in positions of dependency. Similarly Walker (1993) argues that case or care management tends to regard clients as being managed and sees the needs of older people negatively in terms of dependency. Middleton (1994) suggests that assessments, rather than starting with the hopes and aspirations of clients and carers tend to focus on deficits and difficulties. McWalter et al. (1994) identify that while this is a necessary component of assessment, a more holistic approach is required. This should build on strengths and coping strategies rather than undermining them (Nolan and Caldock 1996). However the individualisation of need is not always considered a positive, enabling and constructive approach for clients. Community care guidance offers a definition which aspires toward independence as determined by a third party.

“needs are said to show a requirement for individuals to enable them to achieve, maintain, or restore a respectable level of social independence and quality of life, as defined by the particular care agency or authority” (SSI/Social Work Services Group 1991a page 14)

Caldock (1994b) criticises the ‘betrayal’ of such a definition, highlighting the contradictory language of independence, participation, user control alongside that of managerialism and professional control. With already elusive terms, apparent discrepancies in policy add to the ambiguity. Caldock (1994b) also draws attention to the section of policy guidance which states that competency assured, the users’ view should carry the most weight (DoH and SSI/Social Work Services Group 1991a page 14).

Despite the policy plea, attention is drawn to the conditional component which states that,

“ultimately the assessing practitioner is responsible for defining the users 'needs'” (SSI/Social Work Services Group 1991a p53)

### **2.5.1 Factors Encouraging Needs-Led Assessment**

Richards (1994) asserts, with reference to community care guidance, that effective implementation of a needs-led approach depends on creating a clear separation between the task of needs assessment and care management. Therefore practitioners must distinguish between the assessment of need and the consideration of the service response to avoid predetermination of the outcome of an assessment. She commends that,

“To identify need appropriately, practitioners must have an unimpeded view, free from the distorting effect of service considerations” (Richards 1994 p5)

One way to facilitate this process is the separation of needs assessment and subsequent decision-making about eligibility. This depends on the concept of need operationalised independently of the agencies' policies and guidelines (Richards 1994). Unless such a separation is maintained many authors suggest that the distinction between service driven and needs-led assessments becomes less apparent and meaningful (Davies and Challis 1986, Percy – Smith 1996, Worth 1999, Parker 2000, Young 2003): the consequence will be a definition of need in terms of eligibility criteria for specific service interventions.

### **2.5.2 Needs-led Assessment Process and Models for Care Planning**

Assessment in many disciplines is treated as a stage within a wider process: that process being a cycle of events. In a nursing context, the Nursing Process (Yura and Walsh 1988) provides the conceptual

framework for models of care. Clarke (1990) describes the Nursing Process as being concerned with individualised and total patient care: 'individualised' describing patient-centred; 'total' embracing the physical, psychological, social and spiritual elements. Ong (1991) states that one of the biggest issues in nursing is that the theory of nursing models promotes the idea of holistic assessment yet the reality of service provision is far from holistic. This, she relates to a lack of case management and finances, culminating in assessments which are piecemeal.

Essentially the Nursing Process has four dimensions: assessment, planning, implementation and evaluation. The process recognises the relationship between each stage and the importance of order within the cycle. The same exists within social care where assessment is seen as a stage within the care management process. The key factor between the identification of need and implementation of care is that of care planning or objective setting. The care plan has been described as providing continuity: an even flow of care from one professional to another. Because the process of assessment is reflective of the context within which it exists, personal, public and political agendas can compromise the focus. Marshall (1990) suggests that,

"assessment is not something that ever exists on its own but the word should always be followed with 'for what'" (Marshall 1990 p36)

When the 'for what' aspect of assessment becomes the motivation for the process, the performance of the task itself can encroach on the territory of care planning. Planning on an individual basis necessarily involves several stages: aggregation of collected information; identification of needs (both met and unmet); need priority setting; formulation of goals and objectives and design of strategic intervention (Potter and Perry 1987). Nolan and Caldock (1996) suggest that assessment is not an end in itself and cannot be divorced from what follows. Accordingly the critical path following assessment should contain a number of elements described as being; care planning; implementation; monitoring and review. Nolan

and Caldock (1996) also suggest that the final stage of the assessment process consists of 'agreeing the objectives to be met'. The key role of goal setting cannot be overestimated,

"These objectives in relation to need are the benchmarks against which all the subsequent stages of care management have to be measured. Objective setting is therefore the key to effective care management" (SSI 1991b para 3.51)

There should therefore be clear differentiation between the stage of identifying need and that of supplying resources to meet needs. This requires separation of need from eligibility criteria as determined by employing professional organisations. Where assessment and planning occur in conjunction there is a predisposition towards bias and away from 'objectivity' (Richards 1994). Here the argument is also made that unless the separation between assessment and planning is maintained, the distinction between service-led and needs-led assessment will become meaningless. Worth (1998) describes the difficulties faced by community nurses and social workers in the real world of community care who, in light of resource limitations have great difficulty divorcing assessment from the availability of services.

Three components of assessment have been suggested: analysis of the situation, determination of care needs, and relation of needs to options (Middleton 1994). An awareness of available options and incorporation of this as a consideration in the assessment process may lead to a definition of need in terms of service terminology or eligibility criteria. Such activity would mark a retreat from the needs-led approach expected of assessment and community care provision.

## **2.6 Factors Affecting Needs-led Assessment at Practice Level**

Several factors have been identified as influential in the assessment of need: each impacts on the ability of a professional to perform an assessment that is needs-led in focus. Mixed understanding between disciplines of the notion of need and the assessment thereof lends itself to issues regarding inter-rater reliability. Twigg and Atkin (1994) argue that because of the absence of clear and explicit agency, policy and practice guidelines, practitioners have to rely on their implicit knowledge. The three sources of implicit knowledge, describes Nolan and Caldock (1996) are: professional training and values, the culture of the office, and assumptive worlds. Ellis (1993), remarking on current assessment principles suggests that the process is often rooted in the professional identity of the assessor and is thereby limited as a consequence.

Focussing on Nolan and Caldock's (1996) theory of implicit knowledge, factors motivating social work practitioners assessing need are deconstructed. They suggest that the field of community care for older people is awarded a low profile and does not have a particularly strong theoretical base. These factors are exacerbated by a lack of consensus within departments as to what constitutes appropriate and effective interventions. However the basis of their reasoning lies in the existence and influence of 'assumptive worlds'. Despite difficulties in identifying supporting evidence that is not anecdotal, there is agreement that subliminal aspects exert a real and powerful influence over the assessment process. Ellis (1993) describes the making of moral judgements about 'deserving cases' as the main factor determining who receives services and who does not.

These fundamental professional, cultural differences are often explained in terms of variations in philosophy, training, agendas, language and ways of working. Similarly there are also indications that different groups of professionals may be unwilling to accept the validity of the

assessments and recommendations of other professionals (Bryans and McIntosh 1996, Smith 2001, Webb 2001, Gambrill and Gibbs 2002, Healy 2003). Reassessment by other professional groups to confirm or deny assessed needs undermine the envisaged benefit of a single care manager with responsibility for planning and implementing care (Caldock 1993).

Runciman (1989) applies similar comparative principles to the assessment process of health visitors suggesting they experience difficulty working with older people because of a lack of a consistent focus or framework pattern for assessment. Bryans and McIntosh (1996) while considering the decision-making activity of community nurses identified intrinsic and extrinsic factors fundamental to the process. Here, the community nurse is described as a uniquely programmed and constantly self-programming individual. Extrinsic factors such as information derived from external referral sources, contribute to the process of decision-making however emphasis is given to the place of intrinsic or intuitive behaviour. Bryans and McIntosh describe the link between the use of 'experientially gained knowledge and that of intuition in pre-decisional activity'. This not only exerts a strong influence over the assessment of the client's actual needs but has direct implications for goal setting.

## **2.7 Needs Assessment Approaches in Health and Social Care**

Donabedian (1973) describes need for health care as being perceived and assessed in terms of three different although related phenomena: need has been applied to states of health or ill health, the use of services and, levels of supply. It is highlighted that for the purposes of planning, it is usually necessary to incorporate all three aspects. Slade (1994) also endorses an approach to need assessment which adopts a perceived as well as a normative definition of need, however Slade does raise the issue of objectivity in the practice of assessment of need suggesting that,

"The measurement of need cannot be objective, but rather should arise from negotiation between the user and staff members, and should take account of the users' cultural background. An

assessment tool for everyday clinical use should go beyond symptomology and behaviour observed by professionals, and incorporate the users' perceptions" (Slade 1994 p295)

Hamid et al. (1995) describe the main objectives and uses for needs assessment in mental health care mainly in relation to the effective targeting of existing resources and development of new responses to meet needs. This however assumes that some needs require services and that unmet need may indicate a lack of access to some form of service (Slade 1994). The distinction between population based need assessment and individual need assessment becomes more pertinent. Hamid et al. (1995) suggest that the assessment of mental health care needs of individuals is normally based upon either a problem-orientated assessment or need for interventions. They challenge the problem orientated approach which has as its base a disease model focussing mainly on signs and symptoms which support diagnosis. It is argued that there is a much larger social element in the causation, course and outcome of mental health problems than physical medical problems, and that psychiatric diagnoses tend to exclude the social aspect of mental health problems (Wing 1989).

Psychiatric diagnosis it is contested is not a good indicator of needs for mental health services for a variety of reasons: social disablement is considered a more satisfactory measure of need for particular services. Wing (1989) defines mental health care as the interventions necessary to reduce social disablement or to enable other caring agents to do so within what is feasible at the current state of knowledge. Assessment of need in this capacity is described and classified by Stewart (1979) into three components: the first concerns the identified problem within the social context of the patient, the second involves the desire of the person or community to solve the problem and the third component is the solution based upon the analysis of the problem and the desire. Identifying needs and planning care for individuals and communities therefore incorporates these aspects and Hamid et al. (1995) call for increased recognition of the



desires of those being assessed. This is a sentiment reflected in SSI guidance on assessing need:

“Needs are often professionally categorised in a way which fails to capture the desired outcome from the user’s and/or carers’ perspective” (SSI 1991 p52)

Yet descriptions of social care definitions of need and assessment are often typified by the centrality of the user and carer perspective and choice in joint decision-making processes. The International Association of Schools of Social Work (2001) asserts that social work as a profession:

“Promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance wellbeing. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work” (International Association of Schools of Social Work 2001)

A review of social work within Scotland (2006) identified components which distinguished the role of social care from that of health care with key findings highlighting the person-centred nature of social care and ongoing case or care management. The skills, knowledge, expertise and professional protection required in order to effectively case/care manage has been highlighted in several studies which document the intricacies and dilemmas faced by social care professionals in the assessment and delivery of care (Lloyd 2000, Challis et al. 2001, Stalker and Campbell 2002, Postle 2002, Weinberg et al. 2003).

### **2.7.1 Practice Perspectives on Health and Social Models of Care**

Caldock (1994a) highlights that much of the assessment documentation following community care reforms appears to continue to place a heavy emphasis on functional capabilities, activities of daily living, problems and

dependency. A study by Worth et al. (1995) considers the assessment of need in district nursing and supports these findings reporting that community nursing assessments were described by social workers as being dominated by the medical model approach, paying inadequate attention to client and carer choice. This was particularly evident with regard to clients remaining at home with support rather than being admitted to care. Equally social workers were described by community nurses as being inadequate assessors of health needs and had a tendency to allow people to remain in unaccepted, risk laden situations because client wishes were given precedence over safety.

Conversely a study by Cowley et al. (1996) identified community nursing assessments as traditionally encompassing and integrating multiple perspectives of both covert and overt needs. These included medical, health and social aspects of individuals, families and communities. Assessment was viewed as a continuous, monitoring activity, integral to all community nursing practice, with the emphasis on process and integration (Cowley et al. 1996).

Worth et al. (1995) also identified differences regarding the perceived urgency of and appropriate response to particular needs: community nurses were regarded by social workers as being more concerned with immediate problems than long-term solutions, judgmental about social conditions and having a tendency to overreact to client problems. The study also discovered that when social workers and district nurses talked about their own assessment practice, similar terms were used. Both claimed to take more of a broad, detailed, holistic, client-centred approach than the other and were mutually suspicious about the adequacy of the other's assessment.

## **2.8 The Inclusion of Service Users and their Carers in Needs Assessment**

The White Paper 'Caring for People' (1989) recommends the active participation of users and carers in the assessment process, where possible. Therefore assessment should consider demand as well as need incorporating carers and users. Ong (1991) asserts that if district nurses are serious about understanding people's needs, they have to acknowledge that these needs are socially constructed and closely bound up with identities and expectations. This is in accordance with Government guidance on assessing need, which states that,

"All users [...] should be encouraged to participate to the limit of their capacity [...] Where it is impossible to reconcile different perceptions, these differences should be acknowledged and recorded." (DoH and SSI 1991a p51)

Slade (1994) suggests that inclusion of carer and user views makes the assessment process a more exploratory and useful process yielding new insights and perspectives on the situation. SSI guidance links the notion of quality care with consumer sovereignty (Ellis 1993) and advocates that:

"Instead of users and carers being subordinate to the wishes of service providers, the roles will be progressively adjusted. In this way, users and carers will be enabled to exercise the same power as consumers of other services. This redressing of the balance of power is the best guarantee of a continuing improvement in the quality of service" (DoH and SSI 1991a p50)

Hughes (1995) views assessment as the first stage in a process, which leads to intervention, designed to meet need and improve a person's situation and functioning. Practitioner guidelines acknowledge that the perception of need may vary between assessors, clients and carers, yet it

is the responsibility of the assessor to weigh up all aspects of the assessment and record need:

“Ultimately, however, having weighed the views of all the parties, including his/her own observation, the assessing practitioner is responsible for defining the user’s needs” (DoH and SSI 1991a p53)

## **2.9 Defining the Assessment Process**

Operational attempts to specify elements of the assessment process lack clarity and consensus (Royse and Drude, 1982). Harding et al. (1987) describe assessment as the range of techniques by which conditions, resources and needs are identified. Another description used frequently in relation to assessment of need is that of dependency. Many dependency scores have been devised providing quantitative measurement of conditions traditionally described in qualitative or subjective terms. However the relationship between dependency and need lacks clarity. While quantitative measurements can contribute to and complement the needs assessment process they cannot be considered a substitute. Standardised assessment tools which measure aspects such as behaviour, dependency, risk, depression may reflect to some degree the actual level of these elements, however, they do not interpret the data in a way that is reflective of need and therefore lack the flexibility to accommodate frequent patterns of change.

Defining assessment as a measurement may not appeal to all professional groups. As the interface between health and social needs becomes increasingly ambiguous, clinicians or more scientifically orientated practitioners are being forced to think in less quantifiable terms (Caldock 1993, Worth 1998, McIntosh et al. 2000). Carter (1995) describes the term ‘assessment of need’ as a process via which refinements of service provision and user uptake are made which are accessible, appropriate, efficient and effective. In concordance Futter and Penhale (1996) warn against the persistence of a simplistic, static view of assessment. Life, they argue, is not static but constantly subject to change. Therefore

assessment is considered a process which is better understood within the context of a relationship between cared for, carer and assessor.

McWalter et al. (1994) offer a preliminary definition of need assessment describing it as a staged process: firstly determining the presence of potential difficulties, then assessing the efficacy of current help and hence unmet need, and assessing the needs that these difficulties engender. Assessment should provide the conceptual framework upon which intervention planning can develop and be broken down into a number of discreet activities. These include: noting the problems of which the client or referrer complains, forming an impression of the users' situation, collecting additional information, thinking out the nature of the problem, deciding what action the assessor can take and communicating this to the user. Indeed Harding et al. (1987) describe assessment as a term used to identify the range of techniques by which conditions, resources and needs are identified. The role of the assessor in collating the data in order to form an impression of the person and the situation is pivotal and has raised concerns regarding variability between assessors both intra and inter-professionally and their ability to adequately define needs in a manner that is reliable. Richards (1994) suggest that,

“Instead of being a more or less effective tool for spotting objective needs, assessment is seen as a process of investigation and negotiation, which may lead to a particular situation being characterised as ‘needful’. The research task is to investigate how the perceptions and behaviour of the people involved, and the way in which the process itself is constructed shape the final outcome. This requires the researcher to gain access to the process of defining need as it happens, in order subsequently to explore the social meanings underlying the behaviour observed. It implies a questioning of what is normally taken for granted in order to understand exactly how assessors exercise the power to define need and to what extent and in what ways that power is limited by agency policies and resources, by other professionals and by users and carers themselves” (Richards 1994 p7)

Nolan et al. (1994) suggest that any framework for assessment should meet a number of criteria. It should be flexible and adaptable for use at a variety of circumstances, be appropriate to the audience it is supposed to address, capable of balancing and incorporating the views of a number of groups including carers, users and agencies, and be able to provide a mechanism for bringing together different views whilst also recognising the diversity and variation within individual circumstances.

### **2.9.1 Assessment Process: Implications of Implementing Policy into Practice**

Hostick (1995) addresses the issues of timing and frequency in relation to assessment of mental health needs. If the definition of need is relative then it follows that needs assessment should be an ongoing process, taking into account new developments in health/illness, interventions and measures of effectiveness and user empowerment. Nolan and Caldock (1996) propose a model comprising of several possible levels of assessment according to the type of need and the services to be delivered. The broad categories of need include: personal or social care, health care, accommodation, finance, education, employment and leisure, and transport and access. Guidance advises that,

“In the interests of both efficiency and consumer satisfaction, the assessment process should be as simple, speedy and informal as possible. This means that procedures should be based on what is the least that it is necessary to know” (SSI 1991, paragraph 3.3)

Guidelines assert that comprehensive assessments should be reserved for the minority with severe or complex needs, and suggests that probing too deeply into areas which clients are reluctant to discuss, can be alienating. Furthermore potential danger is perceived to exist with wide ranging assessments where people may be made to describe areas of need they would not previously have considered as such. Conversely a study by McWalter et al. (1998), considering needs assessment tools for dementia sufferers and their carers, found that assessors rated comprehensiveness

much higher than brevity. This, it has been suggested, results in dependency or unnecessary provision of services and equipment (SSI 1991). Nolan and Caldock (1996) argue that this is unlikely to lead to good assessment practice.

Wright (1990) suggests that assessors must overcome what he terms 'brief visitor syndrome': that is the tendency for individuals to present their public rather than their private face to a stranger/professional. He argues that only regular visitors will overcome this and establish the familiarity from which a true picture of a situation emerges. Other concerns over this approach involve aspects such as trust, relationship building, and the need for identification of causal factors. The establishment of trust, a prerequisite for intimate information sharing, is unlikely to occur during a 'speedy' encounter. Similarly the degree of information required to identify actual and potential needs may be simple in design, but necessarily comprehensive in content. There is also an interdependence associated with complex needs: a holistic approach is required to identify the relationship of one need to another, incorporating personal, financial, social, emotional and physical influences.

Assessment on a 'need to know' basis may focus on problems easily identifiable or observable, neglecting underlying or core needs which may then continue to remain unaddressed. Concentration on physical problems is a common criticism and may be accounted for in terms of ease of identification and existence of successful interventions. Hughes (1995) describes the belief that comprehensive assessment, based on arriving at an understanding of the worldview of the client, is the only way to a client-centred system. The route towards achieving this, he claims is through obtaining extensive biographical information which should involve:

"a comprehensive, multidisciplinary and holistic examination of the person's strengths, weaknesses, needs and resources in the round"  
(Hughes 1995 p9)

Ong (1991) points out that in the case of district nursing holistic assessment tends to focus heavily on the client and recommends a wider approach which considers the client and carer in the context of their home environment.

### **2.9.2 Defining the Assessment Task (assessment tools and their applications)**

Returning to McWalter's (1997) definition of assessment as both a process and a task, there is often the misconception that the information gathering aspect of assessment becomes the process and the reporting of that data, once professionally assimilated and interpreted, becomes the task. Where standardised assessment reporting tools are the channel for information recording there exists a professional dilemma between assessing need as determined by documentation and professional practice, experience and expertise.

Middleton (1994) however warns that the search for a magical tool of assessment is a false trail. She criticises the use of tick box systems of assessment describing them as a collection of 'near misses'. Slade (1994) argues that no assessment instruments fully meet the requirements of the NHS and Community Act (1990).

Brewin (1992) categorises existing needs assessment schedules into three types: measuring lack of health, lack of access to services or institutions and, lack of action by lay or professional workers. A measure of a good assessment process in Middleton's view is how well it operates as a decision-making process and not on the quantity of information collected. This is echoed by Ellis (1993) who had cautionary words to say about the dangers of focussing on the instruments of assessment rather than the process itself:

"In implementing the NHS and Community Care Act the danger is that social services departments will concentrate their efforts on service criteria and pro-formas. Developing the tools of assessment



will doubtless be perceived as a less difficult task than challenging the values and attitudes deeply embedded in assessing practice.” (Ellis 1993 p39)

Caldock (1994b) explains that while multidisciplinary functioning presents one set of problems for community care reforms, a second set of factors vital to their success concerns the ways in which assessment is conceptualised within and between disciplines, with particular regard to the longstanding differences in perspective between social and medical models of care. Within a social work context, Bonuck (1996) warns against narrow thinking and describes a lack of development in assessment theory.

“The limitation of traditional needs assessments is that they often become ends in themselves rather than means to ends, or a strategy for social change [...] This preoccupation with measuring need, rather than discovering its causes remains true of even relatively recent needs assessments [...] Needs assessments that ignore the causes of unmet need are limited in their ability to guide ameliorative action.” (Bonuck 1996 p30)

Meyer (1993) attributes the lack of development of assessment theory to pressures on social care staff to think too narrowly in the face of large problems and complex events despite having the awareness of possible constructs including social, cultural and physical environments. This is contrasted with health services research models, which emphasise causality. Differing approaches have raised issues over reliability of assessments carried out by different professionals within the community.

### **2.9.3 The Reliability, Validity and Acceptability of Needs Assessment Recording Tools and Assessment Models**

Carter et al. (1995) ask the question whether assessment of need is simply a matter of fact or a value-laden concept? Certain criteria are considered in relation to needs assessment including validity, reliability

and acceptability: all of which influence its effectiveness and application. Toner (1991) describes that on a pragmatic level, a good assessment is reliable, valid, comprehensive, acceptable and justifiable. He acknowledges the relationship (both complementary and contradictory) between these elements and settles for a tool which demonstrates a compromise between them. Reliability, he describes as the consideration of consistency of accuracy of information received using a particular tool i.e. the extent to which a test if repeated would give the same answer. The two most common aspects of reliability that are measured are inter-rater reliability and test/retest reliability. In relation to individual assessment of need, Toner (1991) describes the importance placed on reliability and warns:

“We need to be wary of the danger of assigning a number or grade which then magically appears to acquire a mantle of truth – without knowing how reliably it has been arrived at.” (Toner 1991 p4)

Validity is also a necessary component of a needs-assessment tool and questions whether a test measures what it is meant to be measuring. This should extend beyond face validity and should be demonstrated quantitatively and qualitatively. Toner (1991) considers the importance of ecological validity and the consideration of factors that are determined by age, sex, culture and the transferability of information collated from one assessment within and between particular population groups.

Similarly Toner (1991) describes tensions regarding needs assessment tools whose content ensures comprehensiveness which in turn affects the acceptability of the tool for particular client groups. If individuals do not co-operate with an assessment tool then results are to that degree invalidated; therefore attention must be paid to the acceptability of the tool for the individual being assessed. Similarly the tool must be acceptable to the assessing profession; however Toner (1991) cautions against weighing too heavily on the acceptability of a tool at the expense of other elements:

“Acceptability should not, must not, mean sacrificing validity, reliability and comparability of results” (Toner 1991 p11)

Lastly Toner (1991) commenting on justifiability, and the principle that no assessment should be done unless it leads to an appropriate outcome (except in the case of research), suggests that some difficulties may be encountered as assessors, following community care guidance, assess need for which no appropriate services exist. The outcome for assessors involves a balancing act whereby individuals may not consider the assessment justified in terms of service intervention; however aggregation of needs-related data will influence prospective service planning, thus justifying assessment in the long-term.

Toner (1991) suggests four main ways to gather assessment information: self report, behavioural ratings based on the opinion of an informant, direct observation by the assessor, and performance tests. Whilst advantages and disadvantages are attributable to each, it is recognised that components of the above ought to be considered when recording needs-related data. The extent to which each is applied relates not only to the context of the assessment but the assessor and the assessee themselves, taking into account differing perspectives.

## **2.10 Assessment, Care Planning and Resource Allocation for Individuals and Communities**

Traditionally the ‘problem orientated’ individual needs assessment defines need in terms of the problem or deficit in functioning or deviation from a particular norm (Hamid et al. 1995). Within health this involves the use of diagnosis or disability as a measure of need. Alternatively the ‘need for interventions’ approach to individual needs assessment focuses on the requirement to implement predetermined solutions. Needs can therefore be translated into service equivalents and are frequently described as such in practice. Donabedian (1973) suggests that services can be translated into their capacity to satisfy need. Hamid et al. (1995) suggest

that this introduces the conceptual notion of a 'need for' particular interventions which is practised at individual and population levels.

The assessment of population needs is not in itself, a statutory requirement (Stalker 1993) however the NHS and Community Care Act (1990) does state that local authorities, within community care plans:

"will be expected to set out their assessment of the needs of the population they serve" (NHS and Community Care Act (1990) para 5.10)

Cornwell (1992) describes that for the purposes of service planning, need is traditionally and primarily defined normatively. Stalker (1993) asserts that although comparative need is frequently addressed and perceived need may be sought, the basis for service planning and development incorporates a mainly professionally defined perspective of need. Several methods inform population needs including: service use statistics, epidemiological data, problem incidence, social indicators, gathering informal opinions, surveys, and secondary analysis of existing studies. Some authors conclude that a best-bet approach incorporates a variety of measures gathering both qualitative and quantitative information to inform service planning.

National prevalence rates combined with local demographic data are frequently employed to identify unmet need; however authors caution that diagnosis is not a good predictor of service utilisation. Stalker (1993) describes the use of registers, information systems and consultation processes as sources of information about unmet need. Similarly uptake of existing service provision is also utilised for planning purposes as is information collated by inspection units and through complaint procedures. Bell (1993) describes the use of health profiling as a method of defining need within communities or client groups. This is an activity normally undertaken by health visitors and is described as one of the great strengths of health visiting albeit underused (Orr 1983). Stalker (1993) also cites the aggregation of individual assessments as a means of

evidencing need and informing service planning. Harding et al. (1987) asserts that:

“Unless comprehensive information is collected systematically about the extent to which identified needs of individual clients are being met by local services, neither health authorities nor social service departments can allocate funding and resources objectively for rational service planning. New methods are required that allow this process to occur for individual consumers” (Harding et al. 1987 p137)

Stalker (1993) suggests that several aspects need to be addressed before service planning is as successful as it is intended to be. These include: the development of collaborative mechanisms for joint planning; clarification of terms e.g. needs and populations; more information and sophisticated methods for collecting and analysing data; new creative and flexible ways of involving users and carers in service planning, and design and support for visionary elements in service planning. Unless these issues are appropriately addressed within communities, Harding et al. (1987) describes the tensions, which may arise between the demands created by planning for individual clients and those relating to wider service development. They caution that the needs of the individual or minority may be in danger of being forfeited for the needs of the majority,

“Individual needs are frequently compromised in the wider interests of medical/administrative convenience” (Harding et al. 1987 p141)

Carter et al. (1995) commenting on epidemiological approaches to mental health needs assessment describe difficulties in analysis, interpretation and utilisation of needs assessment data because of a lack of agreement on operational definitions of, in this case, mental illness and the non-standardisation of needs assessment approaches. Balacki (1988) suggests that different concepts, methodologies and meanings of need produce different sorts of information about what is needed, how much is needed and who it is needed by. In terms of outcome, Carter et al. (1995)

speculate that bottom up and top down methodologies differ in that a client-centred needs assessment (i.e. bottom up) may result in a more localised, more flexible and responsive means to establishing and evaluating the expressed needs of people with mental health problems. Richards (1994) describes in some detail the responsibility placed upon policy makers to define what constitutes eligible need i.e. the need for which a service should be provided. Returning to government guidance the tasks involved are made explicit,

“In the context of community care, need has to be defined at a local level. That definition sets limits to the discretion of practitioners in accessing resources. Consequently there is an onus on elected members and board members to revise the policy framework within which managers and practitioners are asked to operate. A needs-led approach requires needs to be explicitly defined and prioritised in policy statements” (DoH 1991 p12)

## **2.11 Chapter Conclusions**

The identification and/or assessment of need is predicated on many factors and undertaken within a host of frameworks. No standardised model of assessment is applied universally although certain underpinning values determine the assessment and decision-making activity of the assessing professional. This chapter has examined the concepts of need and assessment in policy and practice including professional perspectives. The complexities of the principles associated with needs-led assessment, alongside the context of implementation within caring professions makes generalisations very difficult. In light of some of the apparent contradictions described, several causes and solutions have been volunteered.

Recognition of users and carers as consumers and not merely contributors to assessment procedures and resource allocation, demands a radical reorganisation of thinking patterns. Several forms of documentation have been introduced in order to facilitate the transition from thinking to

behaviour. To ensure that new procedures do not simply become a paper exercise, Nolan and Caldock (1996) note the suggestion that assessment documentation which is too long and complex could be discarded, possibly in the favour of client specific approaches.

Assessment has resource implications not only relating to service provision but also availability of assessors and the allocation of time. Investment in the assessor rather than the assessment may remove some bureaucratic obstacles presents idiosyncrasies of its own. Professional vulnerability to external and internal constraints may compromise objectivity, 'subjecting' users and carers to a process, which has little grounds for reliability. There are possible solutions. Firstly the separation of assessment from care management - this would serve the multiple function of shielding time whilst developing specialised skills in the area of assessment. Meanwhile the influence of external restraints would be minimised (such as scarce resources, eligibility criteria, time restrictions). Also the removal of accountability and responsibility for service provision post-assessment may liberate some of the constraining pre-decisional activity already identified. Secondly it is clear that values inherent to practice play a major role in fashioning attitudes towards assessment. Assessment is fundamental to the policy and practice of health and social care and as such is given great emphasis in training and education. Values adopted during training could precipitate or militate against the culture of change which typifies the world of health and social care.

Nolan and Caldock (1996) assert that at conceptual and inter-professional levels, there is a need for a more precise and shared definition of how to achieve a needs-led assessment. At interprofessional level solutions have been suggested in terms of assessment, care planning and joint training initiatives. Training curriculum designed to accommodate changing patterns of practice which allow development of good assessment skills will contribute to community care implementation criteria (Runciman 1989, Boyce 1996, Keene et al. 2001, Torkington et al. 2004).

Finally concurrent development of an assessment procedure or protocol, the design of which is: comprehensive to discourage narrow mindedness; holistic to avoid territorialism; objective to dispel managerialist tendencies, and acceptable to users, carers and assessors alike, will help the assessor function independently and efficiently in the new needs-led culture (McWalter et al. 1994).

Having considered the factors culminating in the implementation of needs-led assessment. Chapter Three will introduce and explore research methodologies to elicit responses to broad based concepts around needs-led assessment.



## **CHAPTER THREE**

### **3 METHODOLOGY - JUSTIFICATION AND DESIGN**

#### **3.1 Chapter Introduction (including Research Questions)**

Following a review of the literature, several key research questions emerged in relation to the practice of needs-led assessment in community care. It was the aim of this study to consider these questions alongside the appropriate methodology to elicit representative responses from participants, mainly health and social care staff. These questions can be summarised:

- What factors influence the assessment of need?
- What is the relationship between needs identified and needs recorded?
- How is need defined and conceptualised by assessors?
- What factors influence the extent to which needs are addressed?
- Are assessors influenced by their ability to address (or not address) need whilst undertaking an assessment of need?
- How is assessment defined and conceptualised by assessors?
- What professional differences (if any) exist with regard to the assessment of need and addressing need?

General study supplementary questions included:

- How important is it to perform needs-led assessment?
- What are the benefits or drawbacks of performing needs-led assessment?
- Does performance of needs-led assessment influence the outcome of the assessment?

It was acknowledged that due to the integral nature of assessment for health and social care, responses to such questions would not always be

consciously accessible to assessors. The more automatic a thought process or an action becomes, the less likely that individual is to identify and describe specific components of a much wider process. Therefore the methodology identified sought to reflect this and offered assessors the opportunity to explicitly identify elements they were consciously aware of, whilst allowing the interviewer the ability to identify and explore elements which were implied and which influenced assessors more subconsciously. This mixture of implicit and explicit influences, and therefore subconscious and conscious elements, was explored during each interview in order to fully understand needs-led assessment and the factors which influence, encourage or inhibit its practice.

This chapter presents an overview of methodologies available for use within the study, identifies the rationale for choosing sequenced vignettes (or case studies), and discusses the internal and external validation components of developing and using this preferred research methodology.

### **3.2 Qualitative Methodology – an Overview**

For the purposes of identifying and exploring themes which emerge as a consequence of complex decision-making activities (conscious and sub-conscious) qualitative methodologies offered a wider variety of choice and flexibility than quantitative. Qualitative research methodologies differs from quantitative in relation to various elements including perceptions of reality, the relationship between the researcher and that being researched, and the role of values. Quantitative methodology is approached using a deductive form of logic wherein theories and hypotheses are tested in a cause and effect order. The intention of qualitative research is to develop generalisations that contribute to theory and enable better explanations, predictions and understanding of a given phenomenon.

### **3.3 The Choice and Rationale of Study Research Methodology**

Miller and Dingwall (1997) explain that in the natural sciences, findings are validated or verified by their independent replication: whereas in sociology, validation cannot occur in subsequent replication as identical social circumstances cannot be recreated outwith a laboratory (Creswell 1994). Since social life contains elements that are generalisable across settings, and those that are particular to given settings there are limitations to the predictive power of social sciences.

Following a review of literature, it was evident that more than one factor influenced the assessment of need. In reality it is impossible to control events in order to predict or anticipate the process or outcome of needs-led assessment. No two individuals are the same and neither are situations, though there may be similarities. In order to consider and compare the practical reality of needs-led assessment in community care, designing a methodology that accurately identifies the key considerations is difficult.

In choosing a research methodology which adequately captured the research questions and allowed the emergence of new material, the author focussed on qualitative research methodology using vignettes. Vignettes are short descriptions of hypothetical persons or situations which contain the information necessary for respondents to base judgements upon. Vignettes can vary in number and can be short and simple or longer and more complex. Vignettes activate respondents' imagination and interest which supports their engagement in the research process (Poulou 2001).

Vignettes have played an important role in social work research including longitudinal studies, cross cultural research, comparative research between groups of professionals and service users (Hughes and Huby 2004). Qualitative interview using vignettes is considered one of the more

appropriate approaches for the study of normative material, “where the direct and abstracted approach of eliciting responses to specific issues is not possible” (Rahman 1996 page 36). To be non directive in approach, qualitative interview using vignettes can be applied in various forms: in some cases it can be used with open ended questions, alternatively with fixed choice responses or a combination of both. The open ended questions allow the interpretation of the situation in question to be defined by respondents. By using qualitative methodology with vignettes methodology, the researcher can elicit information about the particular circumstances specified thus, “tap the general imagery of respondents, but at the expense of some of the more peripheral detail” (West 1982).

The use of vignettes as a research methodology therefore requires a narrow focus which directs responses to reflect specific research questions. This could be considered a constraint or an opportunity to explore key components of complex processes. In the course of considering the research methodology a critique of the use of vignettes was undertaken. The results are outlined in this chapter, alongside measures taken to ensure the study is not restricted or biased as a result of the methodology employed.

### **3.3.1 Research Methods to Elicit Conscious and sub-conscious Decision-making Activity in Needs-led Assessment**

Literature suggests there are several main factors influential in the assessment of need. These include: knowledge of service availability, budget restrictions, presence or absence of an informal carer, nature of disease or disability (Robinson 1993, Barr 1996, Parry – Jones and Soulsby 2001, Little et al. 2002, Bennet et al. 2005). While each may be justified in terms of ‘informing’ the assessment process, there are times when these considerations influence, or are considered to ‘corrupt’ an assessment of need that attempts to be needs-led.

Bryans and McIntosh (1996) detail the stages involved in the decision-making process of community nursing staff related to assessment

practice. These are separated into factors intrinsic and those extrinsic. Intuition, information, clinical knowledge, expertise and experience are considered intrinsic to pre-decisional activity which determines the assessment of need. Extrinsic to this process are 'real world constraints' such as caseload demands and the availability of local resources. Bryans and McIntosh (1996) consider these concepts in relation to the 'seven stages of decision-making' outlined in previous work by Carroll and Johnson (1990). These include,

- Recognition
- Formulation
- Alternative generation
- Information search
- Judgement or choice
- Action
- Feedback

Although these stages are listed in sequence, Carroll and Johnson (1990) suggest that they may not occur sequentially, but may repeat and backtrack in a complex manner. This demonstrates that assessing need is not always a consequential progression of logic but a complex process unique to those involved. The need to choose a study methodology which captures the intricacies of an ambiguous concept, subject to intrinsic and extrinsic factors is critical. It requires an approach that allows for interdisciplinary differences, accommodates individual perspectives and accounts for multiple influences. The use of case studies in the form of sequenced vignettes, allows for a degree of consistency and control over the information presented to study participants, which therefore facilitates the management of multiple responses.

While certain factors can be 'controlled' at a professional level e.g. uniformity of basic training, standard protocols and procedures, there are other critical factors outwith the realms of professional programming/conditioning. Personal experience and professional expediency will have qualitative effects on the assessment process but

are factors difficult to identify, assess or 'control' for the sake of researching their existence and degree of influence in the assessment process.

Given the intrinsic and extrinsic factors involved in the complex decision-making process, it is unrealistic to expect assessors to identify all the elements that influence their assessment of need. It is further complicated by the fact that many of these influences are subconscious, and this very fact makes them so influential in the decision-making process. To explicitly ask professionals (either within an interview schedule or on written questionnaires), what factors influence their assessment of need, would therefore only produce responses reflecting their conscious perceptions which is an incomplete picture (Cavanagh 1997, Bensen and Hatrz 2000, Concato et al. 2000, Webb and Kevern 2001). The consideration and exploration of sub-conscious elements that influence professionals undertaking a needs-led assessment requires a methodology which elicits overt and covert decision-making activity (Teresi and Holmes 1994, Endacott 1994, Koch 1994). In addition, the chosen methodology requires to be flexible enough to facilitate the expression of responses to controlled information as well as the ability to explore emerging themes as they present themselves.

Finch (1987) relates the ongoing difficulties sociologists experience when studying beliefs, values and norms. These methodological problems, she relates, are not merely technical but,

“reach to the heart of theoretical and philosophical questions about the relationship of individuals to social structures, the extent to which human action can be assumed to reflect a world view (and if so, whether this can be verbalised), and in what ways human actions are shaped by cultural perceptions or ideological forces” (Finch 1987 p105)

Finch also makes the point that these problems, when studied using survey research are further compounded by the constraints of question

wording and coding. She states concern that there is reliance upon crude and highly questionable attitude measurement scales and that even "the most sophisticated and thoughtful survey researchers find that it is extremely difficult to study values in a convincing way" (Finch 1987 p105).

### **3.3.2 A Critique of Methodological Options to Consider Needs-led Assessment in Practice**

Identification of extrinsic and intrinsic influences to the assessment of need demands an approach that can account for both overt and covert factors within the assessment process. One option is to consider the assessment process in action. Observation is one of the most commonly used techniques in the field of social science since it allows the researcher to follow processes as they actually occur. Used in conjunction with participant interviews, this technique can facilitate the answering of the key questions. Participants can be observed during an assessment of need and then asked to justify their assessment after the event. During such interviews, factors influential to the process can be explored. This technique takes into account differences between assessors (such as professional experience and training) and may also account for external factors such as service availability and accessibility. However, it would still be difficult to 'control' the situation in terms of other significant factors such as client variance across cases and transferability of results between situations and clients. There will also be ethical considerations with regard to the researcher observing assessments as this intrusion, however minor, may influence or corrupt the subsequent outcome.

The 'Hawthorne effect', (Adair 1984) has received much publicity though not all appears to be evidence-based (Adair et al. 1989). Despite criticisms, there is a belief that being watched has an effect on participant response. Were this study to be conducted using observation, this may affect the amount of information divulged and/or desires articulated by the client. In turn it may also cause the assessor to produce an ideal, as

opposed to a realistic assessment of need, such as would be expected under supervision or exam conditions.

The Hawthorne effect is difficult to dispel from any piece of research, but when that piece of research sets out to uncover factors which, in daily activity, may pervert the ability to perform needs-led assessments, there emerges a real risk that the research design or technique in itself contaminates the resulting data. In any piece of research there must be a balance of risk between realistic data and the Hawthorne effect. In this case, it is the author's belief that results obtained by this design would be open to external scrutiny and susceptible to subjective judgement making on the researcher's part. There would also be practical difficulties about third party presence during the assessment of need, which in itself may involve more than one visit and may be informed further by telephone discussions between the assessor and the client and/or significant others.

### **3.3.3 The Requirement for Controlled Variables within Research Methodology – the Example of Vignettes**

In reality it would be impossible to control the amount and type of information received about clients/carers and their situations in order for valid comparisons to be made between assessments and assessors. However the vignette technique reduces personal and situational variance (Vellinga et al. 2004).

Vignettes are described as simulations of real events (Flauserud 1979) and are frequently used in the study of attitudes, beliefs, perceptions and broad concepts (Alexander and Becker 1978, Fox and Dingwall 1985, Finch 1987, Lanza 1988, Poulou 2001, Hughes and Huby 2004). Alexander and Becker 1978) considered their use in studies by social scientists involved in survey research. They defined vignettes as short descriptions of a person or social situation containing precise references to what are thought to be the main factors in the decision/judgement making processes of respondents.



The decision-making activity of individuals and professionals has already been established as a complex process involving various stages of reasoning and judgement making. So complex is this, that to measure responses by simple questioning would reduce the focus of the study to a narrowly defined decision-making component. Any results outside the wider context may lose meaning and usefulness when applied more generally (Flauskerud 1979).

Conversely the use of vignettes allows the researcher to accurately define the stimuli presented to assessors, and in so doing provides a high degree of conformity between situations, clients and carers. This effectively removes much of the scepticism about transferability or reliability of responses to methodologies where the client and conditions vary between assessors. The ability to control aspects considered influential to the assessment of need, allows the researcher to focus specifically on intrinsic and extrinsic components. The use of vignettes allows the specification of prompts received by participants in order to study responses in general. This also facilitates consideration of component parts of the decision-making process by strategically manipulating certain stimuli provided. This technique has proved useful in studies comparing professional responses to fundamental issues or daily encounters (Fox and Dingwall 1985, Peck and Shapiro 1990, Robson 1993, Hakim 1994, Bellman 1996, Gould 1996, Bryans and McIntosh 2000, Bryans 2004).

### **3.4 A Critique of the Qualitative Interview Methodology using Vignettes to Elicit Responses to Broad Based Concepts**

Vignettes are more popular in studies considering broad concepts that can not be easily recognised or verbalised, and therefore difficult to identify using traditional methods such as observation and interview. Flauskerud (1979) lists areas where the use of vignettes are more favourable: anthropologists to facilitate discussions about topics typified with a reluctance verbalise beliefs and attitudes, social psychologists identify

decision or judgement making criteria, clinical psychologists and psychiatrists measure public attitudes.

As vignettes become more popular in the research of beliefs and attitudes, there is a concern that simulations of clients or circumstances may deviate too far from reality and depict unrealistic and idealistic situations (Wilson and While 1998). Flauserud (1979) suggests that before vignettes are used as items in a measuring instrument, they should be evaluated for face or logical validity, content validity, criterion-related validity, or construct validity. Flauserud highlights the importance of internal validity and raises two issues: the need to ensure that the situation depicted in the vignette genuinely portrays the phenomenon of interest, and that each question pertaining to the situation is measuring the same phenomenon.

The opportunity for respondents to be idealistic in their responses to simulations is a concern when vignettes are used to elicit beliefs. The requirement for the development of the vignettes and their application to be as realistic and free from idealistic tendencies is a prerequisite.

#### **3.4.1 Qualitative Methodology using Vignettes - Establishing Validity (Internal and External) and Reliability**

Fundamental to the process of establishing internal validity is that a research item is based on more than the researchers' general impression of the area under study than perhaps on reality. Flauserud (1979) advocated and applied a three pronged approach to the development of vignettes in order to establish internal validity:

1. Vignettes should be a true representation of reality facilitated by the construction of simulations based on real case studies.
2. The dissemination of a selection of prepared vignettes to individuals considered to be experts in the field of study supports the establishment of internal validity. This will, by a process of

elimination, identify those vignettes most realistic and likely to elicit realistic responses.

3. Consideration of ways to determine whether the vignettes and associated questions elicit the type of information necessary to answer the study questions is also required.

Gould (1996) comments that despite Flauserud's concern with internal validity, little information is afforded concerning the generalisation of findings obtained using vignettes, their reliability, or other forms of validity and methodological issues. Studies by Finch (1987), Lanza (1988), Endacott (1997) pay more attention to those aspects of external validity that are considered imperative in establishing the use of vignettes as a reliable and valid method of collecting data concerning concepts, beliefs and attitudes.

Lanza (1990) acknowledges that while there are many benefits to using vignettes (such as standardisation of data collection, control of extraneous variables, and the manipulation of variables of interest), there are also many shortcomings; the main one being that of artificiality. This, she argues, leads to limited external validity. To address this issue Lanza developed a framework to enhance external validity. Following the application of the qualitative interview methodology using vignettes, and semi-structured questionnaires during interviews, this involved consideration of the degree to which findings from simulation research could be transferred to the real world. To achieve a measure of predictive validity, Lanza applied the same measure to hypothetical and real situations and recommended that similar efforts were attempted in order to establish external validity when designing studies using vignettes.

### **3.4.2 Qualitative Interview Methodology using Vignettes – A Critical Review and the Role of Staging Information**

Finch (1987) comments on the positives and negatives of using the vignette technique suggesting that apart from the design itself, difficulties relate to the questions asked and ways in which responses are

interpreted, particularly when complex issues such as beliefs and attitudes are considered. It becomes difficult to evidence whether specific elements of hypothetical situations trigger particular responses.

Finch suggests that respondents 'fill in' (or assume) certain details that may be omitted from the scenario. Ambiguity can therefore be utilised to elicit subjective information although care must be taken where several elements play important roles in shaping beliefs, that vignettes tackle component parts. Finch advocates that in such situations vignettes should be staged so that each element or variable is controlled systematically.

For instance elements such as age, gender, ethnicity, occupation, degree of need can be presented separately and thereby controlled. Finch (1987) also warns against the pitfalls of this approach and advocates the minimisation of controlled elements to avoid information overload and the risk of ambiguous results which occurs when complex elements interact and become indistinguishable as single entities.

Finch (1987) also considers the generalisation of results: vignettes might reflect real life cases but remain hypothetical. Similarly, questions asked are hypothetical and demand responses which, despite requests for realistic replies, remain speculative. How far responses to hypothetical situations reflect practice is an issue for debate.

### **3.5 Chapter Conclusions**

Vignettes were chosen as the research methodology due to their ability to study complex attitudes and concepts. Having reviewed the methodologies and literature describing the use (including strengths and limitations), it was the author's conclusion that a sequence of vignettes, administered within a semi-structured interview, preceded by collection of standardised demographic information would facilitate the exploration and comparison of needs-led assessment activity amongst professional groups operating in the community.

## **CHAPTER FOUR**

### **4 THE PILOT PHASE OF THE STUDY**

#### **4.1 Chapter Introduction**

In order to establish rigour, validity and reliability in the research design, a pilot phase was undertaken following the guidelines provided in Chapter Three. It is the aim of this chapter to describe the purpose, design and results of the pilot phase and relate this component to the final study design.

#### **4.2 Aims and Vignette Design Process for the Purpose of the Study**

Having identified the use of vignettes as a mechanism for eliciting beliefs and influences, (both conscious and subconscious), establishing internal and external validity becomes critical. The use of vignettes must reflect client and situational components reflective of real life referrals for each of the main community care organisations. To avoid organisational bias due to professional expertise, the vignette subject and content must be general enough to present assessment opportunities for the main assessing professionals yet must be specific enough to allow the assessor the ability to express their own particular style, model or method of assessment. These requirements present issues regarding content and client group.

To facilitate professional expression, a staged pilot approach was adopted. Lessons learned at each stage of the process informed the next, therefore what began as an anticipated, logical progression, was customised to reflect the changes identified as necessary.

The overall aims of the pilot process were to:

- Establish a sequence of vignettes for use during the study
- Identify core questions to be asked of the vignettes during the study
- Identify additional questions to be asked during the study to explore wider concepts
- Identify core, demographic information of the sample group
- Establish internal and external validity of the vignettes and the interview questions

The stages and methods of achieving these aims, as determined by the author, are indicated in Figure 1.

<b>Vignette Development Stage</b>		<b>Methods (development and determining validity)</b>
1	Develop vignettes & question criteria	Establish Vignette Development Group (VDG) Define vignette criteria Define question criteria Identify sequenced vignettes & questions
2	User testing (1)	Identify reference group Postal questionnaires to reference group
3	Further develop vignettes & refine questions	Reconvene VDG Review postal questionnaire feedback Develop sequenced vignette options Refine vignette questions Define additional core information
4	User Testing (2)	Postal questionnaires to reference group
5	Pilot vignette sequence & questions	Identify pilot sample group Undertake individual interviews Interview analysis
6	Pilot evaluation	Reconvene VDG Refine vignettes and questions
7	Gold Standard Responses	Establish a Gold Standard Group (GSG) Identify 'gold standard' responses to vignette

Vignette Development Stage		Methods (development and determining validity)
		sequence and questions Identify methodology for comparing gold standard with study results

**Figure 1 The Process of Developing Vignettes and Questions for use within the Study**

During this pilot phase, key lessons were learned about the presentation of vignettes as well as the approach taken to elicit and explore the themes which emerged regarding assessment decision-making activity. Effort was invested to establish internal and external validity. Similarly, prior to the study, vignettes and questions were further refined until they addressed the main research questions as outlined in this chapter. The stages are now considered in more detail:

### **4.3 Pilot Stage 1: The Development of Vignettes and Question Criteria**

To support the development of realistic, generalisable vignettes reflecting common client characteristics as presented to a variety of community professionals, a Vignette Development Group (VDG) was established consisting of professionals in the field of community care. The author considered the constitution of the VDG as critical: membership had to reflect professionals responsible for undertaking needs-led assessment in the community. For this reason membership included a GP, CPN, Health Visitor, Social Worker, Dementia Care Coordinator and a Service Provider (Day Care and Overnight Care). Once constituted, members were asked to comment on the professional responsibilities reflected in the group and the opportunity was provided to widen membership to reflect others engaged in the process of needs-led assessment. It was agreed at that stage that membership was reflective of the main professional groups, although in hindsight the group may have been enhanced by the presence

of a housing representative. This sentiment was only expressed after the task of developing the vignettes was complete. For contextual reasons, housing representatives were included in the actual study.

During this stage the group met on four occasions with the overall aims of: considering factors which might influence the assessment of need; developing a choice of realistic, sequenced vignettes; and consideration of appropriate questions to be asked of the vignettes, including the choice and wording of questions suitable for guiding the desired discussion.

All meetings were chaired and minuted by the author. Written guidance about the use and development of vignettes and the purpose of the study was circulated prior to the meetings and are included in Appendices 1 and 2. Group members were also reminded of the main research areas which included: identification of needs-led assessment as it occurs in health and social care; consideration of factors which influence the assessment of need; and consideration of differences in perception of needs assessment between health and social care staff

The VDG first identified a standardised interview preamble with the purpose of ensuring equity of information provided thereby reducing misinterpretation of purpose and process. The VDG highlighted the importance of reiterating within the preamble the need for 'real life' responses as opposed to text book replies. A standardised interview preamble (Appendix 3) was developed and endorsed by the VDG, with the intention of being presented after the professional's consent to participate in the study. It was also recognised that following the interview preamble, an interviewee might wish to withdraw consent, or consent to only part of the intentions expressed in the preamble. During the course of the study this was shared verbally and as a paper copy with every professional prior to interview.

In order to consider those factors which might influence the professional's assessment of need, an exercise was carried out with the VDG who identified the following key components:



- Presence (and awareness) of resources
- Financial constraints
- Current caseload
- Perceived risk (client versus professional)
- Current care package
- Unrealistic expectations on client's part
- Presence (or absence) of carer
- Sex of client (and carer if and where identified)
- Demanding carers who frequently complain

These components, whilst not an exhaustive list provided the group with a basis for developing a sequence of vignettes: the intention being to include details pertaining to each of the above areas thus prompting further discussion. With these components in mind the VDG set about designing criteria representative of typical case scenarios applicable to each profession represented. Consideration of the content and context of the vignettes meant deliberation over specific details including client group, age, gender, home environment, presence or absence of informal carer, presenting and underlying medical conditions, areas of actual and potential need.

Early on, the VDG identified as essential a client whose needs reflected the skills and professional resources required of a host of disciplines within the community. The VDG suggested the client groupings of mental health, dementia and learning disability as potential areas to meet the generalisable criteria of needs traditionally spanning professional boundaries. Following debate, the areas of mental health and learning disability were discounted by nature of the specialist teams. In terms of the research study it might prove difficult to utilise a case scenario of someone whose needs were considered too specialist to reflect typical client assessment encounters. Dementia was considered a more appropriate client group from which to draw examples of vignettes. The expertise and experience reflected within the VDG identified that clients with dementia were often subject to assessment and care management by a variety of general and specialist community care professionals. It

was therefore the VDG's recommendation to restrict vignette topics to include this client grouping. As this was also the author's area of expertise, further practical insights into the multidisciplinary context of community care for people affected by dementia was accessible.

A list of vignette criteria was then designed by the VDG as potentially influencing the assessment of need. These were separated into sub-headings:

- Characteristics of the person and their environment:
  - female
  - aged 75 years or above
  - suffers from mild to moderate dementia
  - lives in high rise flat
- Problems or need exhibited:
  - social isolation
  - urinary incontinence and recurrent urinary tract infections
  - wanders at times
  - disorientated within flat/s

Consideration was then given to the development of appropriate questions to be asked of each of the vignettes in the sequence, in order to respond to the study objectives. Two overarching questions were identified by the VDG. These were:

- From the information given what areas of need (if any) do you perceive exist?
- For each area of need identified (if any) what action (if any) would you take?

#### **4.4 Pilot Stage 2: User Testing (1)**

Appendix 4 provides the initial vignette sequence and subsequent questions initially chosen by the VDG, which participants were asked to complete as part of the user testing (1). During this part of the pilot, the VDG debated the best means of delivery of the vignette and questions. The main methods considered were postal questionnaires, focus groups and individual semi-structured interviews. For the purposes of the user testing within the pilot it was suggested that postal questionnaires be circulated inviting participants to respond to the vignettes and subsequent questions as they would do in practice. However additional questions were included inviting respondents to reflect and comment on the content and type of information provided including: language, ease of understanding, realism to life, appropriate to health and social care professionals, appropriateness of questions asked after every vignette, postal questionnaires as a method of gathering this type of information.

This proved useful in guiding the next steps undertaken by the VDG. In total five practitioners from across Scotland were invited to respond. Each completed the questionnaires individually and returned written responses to the author which reflected the following similar points:

- Lack of significant change in need status between vignettes – additional information had little impact on previous responses to broad questions
- Response to vignettes were time consuming: respondents felt they were repeating needs identified and actions taken following each vignette
- Insufficient information provided to facilitate adequate responses to the questions posed
- Written responses ranged from single lines to detailed descriptions of needs identified and action to be taken
- Varied perception of level of priority between high and medium

- Some information provided e.g. day care availability appeared too staged and leading – information needed to be more discreet on presentation to avoid 'leading' the interviewee
- Due to uncertainties (gaps in information provided) respondents included additional information which could have been asked, explained and/or addressed during an interview environment
- The scenario represented typical referrals and 'layering' of information reflected the staged approach to information gathering in practice
- Language used and questions asked were considered clear and concise
- Concerns identified about the use of postal written responses when the themes being explored proved difficult to consciously express
- The questions posed, whilst focussing attention on the scenario presented, failed to allow expression of factors underlying decision-making and outcome generation

Within the vignette sequence, a question was included that invited the respondent to rate the degree of risk, urgency or priority. However responses to this question suggested that the terms were ambiguous and required further detail to ensure comparability of responses. The VDG debated the quality and applicability of information this might provide and decided that within postal questionnaires, it should be omitted due to the wide interpretation of terms.

The benefits and limitations of postal questionnaires were also considered in detail. Whilst postal questionnaires might encourage an increase in response, and be perceived as being less time consuming, the quality of information received was questionable. Respondents referred to an inability to interrogate the information further and indicated that this limited their responses as did the lack of opportunity to explain, rationalise or justify their responses. The limited written responses received in answer to the vignette questions indicated the limited level of detail that could be expected during the study itself.

Whilst the information received was useful in considering the research questions, it failed to facilitate the exploration of more subconscious decision-making activities. As the literature review suggests, decision-making within the context of needs assessment involves both overt and covert thoughts and behaviours. Written responses denied the author the opportunity to elicit more subconscious elements. The VDG proposed an individual approach to administering the vignette sequence: within either a focus group setting or individual interviews.

The observation was made that the constitution and deliberations of the VDG (and subsequently the GSG) reflected the focus group model. The opportunity to discuss and debate needs-led assessment in the context of a case scenario, i.e. the sequenced vignette, elicited a wide range of responses not only to the vignette but also on the concept of needs-led assessment. The benefits of this approach were evident in the wealth of information gathered; however limitations were identified including the practicalities of convening groups (time, venue, professional and skill mix), management of 'opinionated' individuals within a group setting, and ability to identify professional or individually unique factors. This was reflected in related literature (Beck 1993, Barnes et al. 2003). Whilst focus groups were not discounted at this stage, the preferred method of administering the vignette approach was considered to be individual, semi-structured individual interviews, a view supported within the literature review (Webb and Kevern 2001).

#### **4.5 Pilot Stage 3: Further Develop Vignettes and Refine Questions**

The VDG received feedback from the user testing phase, and reconsidered both the vignette sequence and the questions posed. The outcome involved the development of four vignette sequences where characteristics and environmental changes were made to the main criteria. This allowed consideration of factors including gender bias, carer needs, and disease progression. Based on responses from the first

vignette sequence, the VDG believed the two original questions failed to sufficiently consider or address the main research questions. To this end the questions were extended and the level of detail refined. It was accepted that the medium of semi-structured interviews would facilitate the application of set questions whilst allowing for the exploration of specific themes as they emerged during the interview. It was agreed that the same set of questions be asked after the presentation of each vignette within the sequence and that additional questions be posed at the end of the vignette sequence, to consider more generally the concepts of need and assessment. The questions agreed by the VDG were as follows:

- What needs do you think exist?
- What other aspects should be considered?
- What skills would you use to arrive at this conclusion?
- What other agencies should become involved?
- What action should be taken in order to meet these needs?
- How do you decide what action should be taken?
- From the list of services/interventions available, identify those you consider appropriate (Comprehensive List)?
- How would you define need and the assessment thereof?

It was also recognised that within a practice/live environment these standardised questions might restrict the natural flow of the interview and should therefore only serve as a guide for the purposes of the pilot.

Furthermore in order to explore the extent to which service availability influenced the assessment of need, the VDG suggested that making service availability knowledge overt within the interview situation might remind the interviewee of 'statutory requirements', compelling them to respond in a manner not reflective of every day practice. In order to explore the extent to which knowledge of services and their availability affected assessment practice it was suggested that a comprehensive, 'wish list' of resources be supplied at the end of the interview with respondents invited to choose those they would introduce.

Similarly, it was felt that conscious and subconscious perceptions of need and assessment - alongside professional idiosyncrasies displayed in the undertaking of assessment related activities - could not be fully explored by analysing the responses to scenario specific questions around needs identified and action taken. It was therefore suggested that the four vignettes be supported with a final section considering beliefs about these areas. Therefore in the last part of the interview schedule, standardised questions were posed regarding definitions of need and assessment. The aim was to further refine the questions based on the outcome of pilot interviews.

#### **4.6 Pilot Stage 4: User Testing (2)**

Having extended the choice of vignette sequences and refined the subsequent vignette questions, further user testing (2) was undertaken with postal questionnaires. Appendix 5 includes the choice of vignette sequences and questions. During this stage the sample group was increased whilst remaining multidisciplinary. Fourteen community practitioners and service providers from across Scotland responded by reading the choice of vignette sequences and subsequent questions and commenting on:

- language
- ease of understanding
- realism to life
- appropriate to health and social care professionals
- appropriateness of questions asked after every vignette

Respondents were invited to identify one vignette sequence which proved the most realistic and appeared to meet the study criteria. The content and written presentation of the vignettes followed a similar pattern from the first approach. However, certain pieces of information were altered in order to identify any significant changes in approach by respondents e.g. changes were made to gender, carer details, and underlying chronic disease. The aim was to consider the application of the initial criteria set

by the VDG in a practice environment and to test assumptions made by the group about the practicality and generalisability of the data and subject matter. Critical to the outcome of this aspect of the pilot were the responses elicited by the questions, and account was taken of potential misinterpretations, duplication of responses and clarity.

Once respondents identified a preferred vignette sequence they were then invited to respond to the vignette questions for that particular sequence. Of the fourteen respondents, twelve favoured vignette sequence (3), commenting that it was the most realistic, least ambiguous in wording, and a scenario common in everyday practice.

#### **4.7 Pilot Stage 5: Pilot Vignette Sequence and Questions**

The VDG concluded that in order to explore the research questions fully (and to elicit the most realistic life responses to everyday scenarios), vignettes provided a good medium. Semi-structured interviews were favoured over postal questionnaires and focus groups as it proved essential to explore emerging themes in more detail which could only occur timeously during individual interview situations. The vignette sequence had to be clear and unambiguous - as well as applicable to a wide range of sample practitioners. Predetermined questions applied after presentation of each vignette facilitated standardisation of approach and allowed comparisons to be made during analysis of the data.

Whilst the vignettes and questions developed appeared to facilitate responses to the main study questions, the VDG also identified the need to gather core demographic information regarding those interviewed. Key components included:

- profession (and designation)
- age
- gender
- duration of employment in current role/post
- duration of basic training course



It was also considered important to ascertain whether the performance of needs assessment was a regular responsibility of the interviewee. Whilst the study focuses on the practice of needs assessment, it is recognised that practitioners now face a myriad of responsibilities, many of which are assessment related. In order to capture a realistic cross section sample it was decided that interviewees would not be excluded if performance of needs assessment was not a regular occurrence. However, in the course of sampling and interviewing the author would ensure that the number of interviewees who respond negatively to the question: 'Do you perform individual needs assessment regularly?' would be kept to a minimum.

#### **4.8 Pilot Stage 6: Pilot Evaluation**

Having undertaken this comprehensive development process, the next phase of establishing internal and external validity involved the use of the defined vignette sequence and question set within a small pilot. The purpose of the pilot was to simulate the study discussion whilst considering the content of the vignette, the wording of questions, types of responses and interview time required. Participants, once recruited, were asked to comment at the end of the interview about the clarity of discussion, the use of the case studies and were invited to make recommendations as to how things might be improved before the study commenced. In total twelve practitioners within South Glasgow were interviewed by the author during the pilot using the semi-structured interview schedule outlined in Appendix 6.

In order to analyse responses to specific study questions, instances of key themes were graphed using excel. This however proved cumbersome and a more general approach was taken to describe the frequency of responses and key themes as they emerged.

#### **4.8.1 Study Sample Characteristics**

The sample group for this pilot consisted of: 3 social workers, 4 social work assistants, 2 district nurses, 1 health visitor, 2 CPNs. All 12 interviewees considered themselves to perform needs assessment on a regular basis. The average age of interviewees was 41 (range from 31 – 55). Nine were female and 3 male. The average length of employment in current post was 4 years (range from 2 years to 13 years), while the average time since qualified was 13 years (range from 2 years to 25 years). The average duration of basic training course (where applicable) was 3 years (range from 2 years to 4 years). There was no difference between health and social care workers interviewed in terms of average duration of basic training course.

#### **4.8.2 Interview Observations**

Interviews were pre-arranged by the author with the permission of the interviewee and their general manager. All interviews were conducted by the author and recorded using a Dictaphone. Interviews were later transcribed verbatim by the author to facilitate detailed analysis. Brief notes were taken during the interview with the consent of the interviewee. Interviews were conducted within a suitable space within the interviewees' workplace and at a time convenient to them. Interviews varied in length from 20 minutes to 60 minutes with an average of 45 minutes. Interviewees were informed in advance of the rationale, nature and structure of the interviews and were invited to comment about the experience afterwards. Results from the interview scenarios and schedule were collated as was the feedback received about the process of being interviewed and general recommendations.

#### **4.8.3 Pilot Vignette Results**

Presentation of three vignettes within the sequence and application of the semi-structured questionnaire after each vignette provided valuable information regarding the interpretation of information and the likelihood

of particular responses. On presentation of Vignette (a) needs were consistently identified within the following categories:

- mental health
- urinary incontinence
- personal hygiene
- mobility
- housing
- finances
- socialisation
- carer's needs

These categories continued to emerge following Vignettes (b) and (c); although by the last vignette comments were more general and often involved 'I would respond as before but with more urgency' or 'the carer's needs become more important than the client's'.

Interesting observations were made between what people identified as needs and how they described these when asked the first question - 'what needs do you think exist?' Some health respondents, in particular CPNs, described the symptoms, investigation and treatment of dementia in great detail; others simply identified dementia as an area of need. The manner in which needs were described was of particular interest – the majority of respondents identified a need for a particular intervention. In most cases this was expressed as a need for a service or professional referral, assessment or intervention. For example needs described in relation to urinary incontinence were most often expressed as a need for a specialist assessment, referral to a continence service or the provision of continence garments such as pads and pants. It was interesting to note that already needs were being described in service specific language. Only one respondent (with a joint health and social work qualification) identified need as a need within a particular area using language free from resource terminology.

Having described needs in terms of actions to be taken, the later questions referring to 'what action would you take and why?' appeared obsolete. Most respondents duplicated their response to the initial question. In many cases the only additional material contained in response to this question was in relation to other needs considered.

When asked how these needs were identified and what skills were used, most respondents had difficulty verbalising the process they employed: two described it as automatic, a result of professional intuition. Further questioning was required to encourage interviewees to consider and describe the skills, process, experiences, expertise involved in identifying needs. For many respondents the assessment tool used was critical: many could describe the content of the tool or model including specific questions asked and general headings provided.

Models of assessment were mentioned on several occasions, with Roper, Logan and Tierney's model of ADLs and Maslow's Hierarchy of Need being specifically cited. The majority of pilot interviewees described elements of good communication skills including observation skills, interview technique, listening and relationship building as critical components. Another area described in response to how needs were identified related to the perception of need adopted. This also related to the client's and carer's wishes/views as well as the professional's view and in one case the professional's personal standards.

The level of experience was also a factor referred to by several respondents and whilst this was mainly professional experience of similar scenarios, many within this group also referred to personal experience. Lastly in response to this question, the process of information gathering was often alluded to including investigative skills, specialist assessments, information already to hand, informal and professional support.

When asked what factors influenced the assessment of need, a variety of responses were received. Several interviewees duplicated responses to the previous question detailing how they would identify need. The factors

influential in the process of identifying needs were frequently perceived to be equally as influential in addressing needs. Despite some similarities, key and common themes emerged. Resources were referred to by every respondent as an influence: resource responses related to availability, awareness, eligibility criteria, funding, waiting lists, relationships with providers, alternative options and availability of informal care. Experience was also mentioned in relation to this question; however more detail was forthcoming about the nature of this experience as including knowledge of similar situations, disease processes, level of education and intuition. Compliance was also a key feature, and included the cooperation of the client and the carer, their particular preferences and the likelihood of service options being available and acceptable to them.

Similarly the degree to which risk was perceived led to discussions about prioritisation, coping abilities and the significance of problems presented and perceived. The process of recording needs was also described as an influence to addressing need. Again this related to the tool, model and capacity to report unmet and unmeetable need, as well as reducing duplication between agencies. Certain organisational issues were raised including the time available to the assessor to complete the assessment and address the needs.

Organisational values were mentioned specifically by three respondents, however most of the pilot group referred to a general requirement to avoid hospitalisation and admission to long-term care. Peer support was described as a positive influence, as was supervision with senior members of staff. Lastly communication was referred to, but this time in relation to the assessor's negotiation skills and ability to persuade or influence professionals, service users and carers to access particular resources. The majority of respondents referred to the balance between identifying need, accessing resources yet managing client expectations and avoiding disappointment.

After presentation of the last vignette in the sequence, few new influences emerged from any of the respondents. In the main responses were

reinforced by the interviewee. Before further information was sought about definitions and professional perspectives, interviewees were presented with an extensive list of professionals, services, equipment and adaptations. Respondents were asked to identify those they thought ought to be in place by, or directly after, the third stage vignette. Most respondents described this as a 'wish list', and all identified more services on the list than they had described during the interviews. Comments such as 'if only all of this was available' were common and led to discussions about the impact that resource awareness and availability has on the assessment process and the response to identified needs. Most respondents reiterated the parameters within which they had to work, and the balance between need, reality of resource response and managing client expectations. This is typified in the following response by a social worker,

"I find there is a conflict with my job which is to promote client determination but also to meet the needs of the organisation [...] and to resist pressure on their (the clients) behalf, whilst still representing the views of the agency" (Pilot SW002)

The final interview questions referred to the definition of need and assessment which were met with some resistance by respondents who expressed difficulty in describing concepts and processes that had become 'second nature'. Most required additional time during the interview to internally compose their perception or definition of need. Most definitions referred to need as a deficit, requirement, desire or perception of an individual. The requirement to balance the individual's perception of need with the professional's or organisation's was alluded to by the majority of respondents.

When asked to define assessment, the notion of describing and balancing perceptions of need was reiterated by most, as was the requirement to relate need to service access. Many respondents referred to assessment as a process which included information gathering. Social workers moreso

than health workers used the term 'picture' in describing the recording of assessment information for an individual.

Interviewees were asked to comment at the end of the interview about the methods used to simulate real life scenarios in relation to needs-led assessment. The majority of interviewees felt the vignettes were realistic and applicable to a wide range of professionals; however most commented that by the third vignette, saturation point had been reached (i.e. no new insights could be provided), and it was difficult to identify any new needs or influences. A vignette sequence with three vignettes appeared to unnecessarily extend the interview period with little tangible benefit to the process. Interviewees also referred to the questions as being repetitive. Everyone interviewed considered the experience a positive one: nursing staff in particular commented on the fact that they were rarely given the opportunity to reflect on their assessment practice.

#### **4.8.4 Lessons Learned from the Pilot**

Feedback was positive about the use of vignettes to facilitate discussion and produce information relating to controlled data which could be analysed and compared. Respondents appeared to share a general understanding of questions, and discussion following each question was largely directed toward similar subjects. However, responses were repetitive and covered similar themes alluded to in previous questions. For this reason further consideration was given to the wording of the questions. Responses from the pilot suggested that the initial questions around needs that existed generated the lengthiest responses, and provided the interviewer with critical information about how the interviewee approached the assessment of need. The questions therefore following each vignette were reduced, essentially to cover the main areas of need, action to be taken and factors influencing the extent to which needs could be addressed. Discussion generated by questions around these three areas was considered sufficient to address the study

questions, whilst also setting the scene for more detailed consideration about the process and factors influencing needs-led assessment.

The use of three vignettes in the series did make interviews lengthy. In some cases where time was limited, discussion was shortened in order to cover the three scenarios. It was therefore decided to limit the study to two vignettes within a sequence: the second being an amalgamation of Vignette's (b) and (c). Appendix 7 outlines the final vignettes and question set that was employed.

Due to the level and quality of detail extracted from the interview transcripts - and the ease with which this facilitated analysis - it was decided that all interviews within the main study would be recorded and transcribed verbatim. In order to organise the emerging themes the author considered the use of software packages. NVIVO is a social science application which facilitates the coding of data from sources such as interviews: NVIVO appeared to offer the most flexible and user-friendly approach to indicating and organising categories and was identified as the software application of choice for the study. Identification of a framework or 'node tree' within which to code and organise the data was supported by the main themes or categories that emerged from the pilot, and these were programmed to support the initiation of coding for the main study itself. Nodes and their themes were defined from the frequency with which they were volunteered during the study. As new themes emerged with regular frequency, these were added to the tree node structure. Themes were defined as areas which were frequently alluded to by participants, as key components in response to certain questions. Themes were often influential factors, motivating factors or inhibitors.

A key lesson learned from the pilot was the need to adhere to the interview question areas. Interviews which strayed from the semi-structured framework proved difficult to analyse and compare. This reiterated the need to ensure that whilst interviewees should be enabled to consider, and progress themes naturally, the interviewer must maintain discussion within the direction of the semi-structured interview schedule.



## **4.9 Pilot Stage 7: Gold Standard Responses**

During the vignette development stage, consideration was given to the notion of a 'gold standard' response to the early vignette questions: 'what needs exist?' and 'what action should be taken?' This could provide a measure against which interviewee responses could be compared and any professional variance determined. A GSG was therefore established and included a range of professionals considered skilled, experienced and expert within the field including a: GP, CPN, Senior social worker, health visitor and dementia service provider. No participants of either the VDG or the pilot interviewees were included in the GSG in order to maintain as much neutrality as possible.

The GSG was provided with background information about the study, its development, methodology and objectives. The group met on two occasions and considered the final vignette sequence (Appendix 7). Each meeting was chaired and minuted by the author. A list of needs was drafted by the group based upon the information presented: which also included appropriate action to be taken. In the absence of a real life client, choices were made based upon professional opinion - although it was recognised that the individual and their carer's wishes would be taken into account in reality, and this might change the service outcome.

When considering each vignette, the GSG produced an exhaustive list of needs and interventions. Full details of the list are included in Appendix 8, however, to summarise general areas of need and intervention included:

- Vignette (1):
  - Cognitive State (orientation and memory)
  - Urinary Incontinence
  - Personal Hygiene
  - Social Isolation
  - Carer's Needs
- Vignette (2):

- Mental Health (including mood and cognitive state)
- Urinary Incontinence
- Personal Hygiene
- Housing (including housecare)
- Mobility
- Social Isolation
- Carer's Needs

During Vignette (2), the GSG considered similar areas of need and actions to be taken, but with a greater degree of urgency than was identified during Vignette (1). The desire to avoid carer breakdown and/or crisis admission to hospital or long-term care was often expressed as the motivating factor.

#### **4.9.1 Reflections from the Gold Standard Response Exercise**

The group included a GP whose responses gave the gold standard response a medical slant: professional hierarchies might have meant that a medicalised approach was not challenged by other group members. Simple group dynamics also affected the outcome. The reality remains that assessment of need is a very subjective practice which is influenced by a variety of internal and external variables.

The exercise of identifying needs proved generally difficult for the GSG because of the various professional perspectives represented. Early discussions focussed on a very medical model where needs could be explained and managed medically e.g. an assumption that there was a definite diagnosis of dementia, that this was both accurate and untreatable. The social implications of the needs experienced by the client and the carer led to debate over who the main client was, and the need to ensure that the needs of the carer were not forfeited for the needs of the client.

The terminology of need was also debated. Some group members preferred terms such as 'issues' or 'concerns' and were reluctant to define

these as needs without interview and full assessment of the client, carer and their situation. For this reason the 'needs' category simply contained general areas - the detail of that particular area of need emerged within the actions to be taken.

The usefulness of the Gold Standard exercise was questioned following the process. Perspectives differed within and between professional groups: reaching a multidisciplinary consensus which was not weighted by a particular professional model proved difficult. This identified the potential benefits of multidisciplinary discussions/contributions to the assessment of individuals. So saying, the dynamics of group discussions did mean that it was not necessarily reflective of individual professional responses. Whilst the scenarios presented were modelled to require multidisciplinary assessment and intervention, lessons learned from the GSG (including group dynamics and interactions), convinced the author that individual interviews proved a more effective mechanism to explore the study questions.

Results from the pilot did indicate that organisational dynamics and culture might play a role in determining the extent to which practitioners were needs-led in their approach to assessment. However the dynamics of group discussions increased the possibility of expression of prevailing beliefs and reduced the opportunity to challenge or explore these as they were perceived by individuals. Similarly, the perception of 'performing well' in the company of peers threatened to undermine the real-life responses that were critical to study. The author therefore concluded that anonymised interviews provided a better opportunity to explore in detail the concept and application of needs-led assessment in practice.

In support of the decision to use interview individuals instead of groups, it was observed retrospectively that gold standard responses proved less comprehensive than those elicited during the main study. This maybe explained by the gold standard response being the product of multidisciplinary group discussions as opposed to individualised interviews.

Having decided to seek responses to the similar questions asked of the GSG during individual interviews it might be considered unfair or unrealistic to expect a professional to reach similar conclusions to a multidisciplinary group. As a benchmark however the gold standard response could act as a useful indicator of the holism of the assessment process undertaken by individual practitioners.

Lastly the exercise also demonstrated personal and professional idiosyncrasies expressed about the assessment of need. As this is a subjective exercise, influenced by a variety of factors, the notion of a 'Gold Standard' may in itself be flawed. The 'Gold Standard' is very much dictated by the model of assessment adhered to e.g. 'needs determined by client's perspective moreso than professional perspective' and vice versa. Therefore in the absence of the opportunity to directly interview clients, assumptions must be made about the extent to which needs impact on lifestyle and personal preferences. Therefore the real 'Gold Standard' might be more of a reflection of the saturation of possible needs and actions as defined by the main study sample, as opposed to a multidisciplinary group tasked with identifying the 'Gold Standard'. The benefit and generalisability of the Gold Standard responses during the study analysis was therefore questionable.

#### **4.10 Chapter Conclusions**

In order to ensure rigour and establish internal and external validity in the study methodology, Lanza's (1990) and Gould's (1996) models served as a framework for the development and user acceptance testing components of the vignette development and pilot phase. Whilst this proved a lengthy and reiterative process, the author was reassured that the sequenced vignettes and subsequent questions, met the criteria of presenting realistic information in a staged way which elicited responses to the research questions.

## **CHAPTER FIVE**

### **5 APPLICATION OF THE MAIN STUDY METHODOLOGY**

#### **5.1 Chapter Introduction**

This chapter outlines the recruitment process and describes the sample group involved in the study. General reflections are also included as these informed the author as the study progressed.

At the time of the study, the author was employed within the South of Glasgow so it was decided that the sample group should be drawn from the North of the city.

#### **5.2 Proposed Sampling**

The study focussed on a wide array of discipline specific designations in health and social care. For contextual reasons it was decided to include housing staff and GPs within the sample. This facilitated a further comparison of professional views in relation to clients requiring multidisciplinary interventions, and also helps identify professional and organisational specific values. The numbers of designated professionals interviewed within each staff group sought to reflect the main professional groups involved in undertaking needs assessments of older people within a general community setting.

#### **5.3 Ethical Considerations**

Data collection for the study commenced in 1998. At that time the author was advised that ethical approval by the Local Research Ethics Committee was not a requirement for interviewing NHS staff. However certain steps were taken to ensure the correct permissions were in place before subjects were recruited to the study. Letters were sent to the Directors of Nursing and Social Work outlining the study aims, objectives and

proposed methodology. Detailed information including the study vignette scenarios and proposed question schedules were also circulated.

Permission was sought to approach staff within these organisations in the North of Glasgow and only once written permission was received did interviews commence. Initial steps involved contacting Locality Managers and Area Managers for health and social work services (contacts were provided by both Directors of Health and Social Work) requesting permission to approach staff directly, inviting them to participate in the study. In most cases managers provided contact details for Team Leaders who were then contacted by the author and, following consent, standard letters were sent to individual members of staff (details were received from local team managers). At this point organisations, managers and potential participants were given assurances by the author that all information received would be anonymised and not attributable. Any information provided that could identify either a team or an individual would not be reported, or if required, would be omitted. Interviewees were also reminded that only anonymised information would be shared or reported within the study itself.

The author also gave careful consideration to a number of ethical scenarios that could potentially emerge during the study data collection:

- Staff might misunderstand the nature of the study and the reason for data collection
- Staff might fail to appreciate that data would be published and therefore be accessible by the public.
- The interviews may become cathartic/therapeutic which might subsequently influence practice either positively or negatively
- Staff might choose to be interviewed for ulterior motives, (e.g. a grievance against their organisation), and their comments would therefore not be reflective of practice
- During interviews staff might disclose practice which placed themselves or others at risk

Strategies were drafted to manage the above situations, should they arise, and every effort was made to ensure both the organisation and interviewees were well briefed in advance of the interview. Reciprocal ground rules were established prior to data collection. As interviews progressed, any concern raised about the potential for harm with respect to information disclosed was discussed during the interview. Interviewees were given the opportunity to terminate the interview and/or be removed from the study. No behaviours were reported that suggested unethical, immoral or criminal practice - and in only one case did the interviewee disclose personal information which the author, for reasons of confidentiality, removed from the interview transcript.

## **5.4 Study Recruitment**

Of those eleven areas contacted in the north of Glasgow, only two declined to participate due to competing staff demands. For other areas, General Managers supplied the author with local up-to-date staff lists and a general letter was sent to each staff member at their respective professional base. The letter (Appendix 9) outlined the study aims and the requirements of respondents should they choose to participate. The letter was followed by a telephone call to establish willingness to participate, and to respond to any questions individuals had. In total 368 letters were distributed and 136 staff members responded over the course of a two month period (37% response rate). Of this group, 77% (105) agreed to participate.

In order to contextualise the study, letters were also sent to housing authorities and general practices within the area inviting participation in the study. GP responses were extremely low (only 2 out of 25 practices responded). Follow up letters and telephone calls were made to respective practice managers, however uptake still remained low. In total only 2 GPs agreed to participate. Twelve letters were sent to housing representatives with a positive response rate of 42%.

Where staff members responded positively to the invitation to participate, telephone contact was made and intent to participate confirmed. Dates, times and appropriate venues were arranged for interviews. At interview the purpose of the study and nature of the methodology was reiterated as per Appendix (3), alongside an explanation of non-disclosure of participant identifiable information. Permission was sought to record the interview. Only one interviewee declined on the basis that the tape recorder might prove a distraction, although it was agreed that written notes could be taken. Participants were then asked again to verbally consent to participate and were invited to ask any questions in advance of the interview. No-one at this stage declined to proceed and in many cases interviewees requested information about the study outcomes.

All interviews were undertaken, recorded, transcribed verbatim and coded using NVIVO by the author, prior to analysis. The tree node structure developed within NVIVO was a direct result of the information gathered during the study pilot although as new data emerged additional nodes were generated.

## 5.5 Characteristics of Sample Group

In total 105 practitioners were interviewed: 45 from social care, 42 from general health care, 11 from mental health care, 5 from housing and 2 GPs. Figure 2 illustrates the breakdown of designations within these broad professional groupings.

Professional Group	Designations	Numbers Interviewed
Social Work	Senior Social Worker	5
	Social Worker	31
	Care Manager	3
	Social Work Assistant	4
	Homemaker	1
	Social Work Student	1



Professional Group	Designations	Numbers Interviewed
Health	Health Visitor	9
	Health Visitor Support Nurse	1
	District Nurse	19
	Community Staff Nurse	2
	Practice Nurse	2
	Practice Development Nurse	1
	Public Health Practitioner	1
	Research Nurse	1
	Nursing Care Coordinator	6
Mental Health	CPN	9
	Unit Manager	2
General Practice	GP	2
Housing	Housing Support Worker	3
	Community Worker	1
	Assistant Chief Housing Officer	1

**Figure 2 Professional Profile of Sample**

Three members of the social work group had dual training: one had worked as a CPN for three years prior to entering social work; a further two had previously worked as district nurses for between 8 and 15 years. The latter were employed as care managers, but assumed the same roles and responsibilities of the social workers within their respective teams.

The sample group was mainly female (82%), with the majority of males interviewed employed within social work. Consideration of age ranges identified the largest group of interviewees (21%) fell within the 46 – 50 years bracket. The age of interviewees was considered alongside length of time in current post and then length of time since qualifying (the latter related only to those with a professional qualification: social work assistants at the time of interview did not possess any professional qualifications). The average length of time since qualified for the whole

sample group was 16 years. The average length of time employed in current role was 7 years.

Of the total sample, 90% identified that they regularly performed needs assessment whilst 10% identified that this was not a regular component of their role. In some cases e.g. Senior Social Workers, the association with needs assessment was mainly supervising and advising staff.

For contextual reasons those who did not undertake needs assessment regularly were included in the study. Needs assessment was considered an essential component of posts held by each of the professional groups interviewed, and whilst this might not have been considered a regular occurrence, each interviewee consented to the interview based on the premise that an intimate knowledge of needs assessment was a prerequisite of their professional role.

The study sample appeared to be a relatively mature group in terms of personal and professional age. Further analysis of workforce demographics would indicate how reflective the study population was in terms of the general professional populations and would be a consideration were the study to be repeated. The study recruitment process might explain the respondents' age: although all members of staff were sent letters, it could be argued that less senior (and therefore younger) members of staff might feel inexperienced and lack the professional 'freedom' to participate.

#### **5.5.1 Interview Venue**

Interviews were arranged at times and venues convenient for interviewees, frequently within the interviewee's workplace. For health staff this normally meant being interviewed at their desk within offices shared by other practitioners. Social work staff rarely arranged to be interviewed in a 'public' setting with the majority being interviewed in designated interview rooms or vacant offices. Therefore social work interviews were less likely to be interrupted by telephones, other

colleagues and general distractions. Lack of availability of quiet space within clinical environments was raised as an issue by health staff, although no objections or discomfort was expressed by interviewees who arranged to be interviewed in the presence of colleagues.

### **5.5.2 Timing and Duration of Interviews**

Significant differences were noted regarding the time to conduct interviews between health and social work staff. Health staff (in particular district nurses), were often only available during lunch breaks or at the end of the day. Interview duration was on average 30 minutes with the shortest interview lasting 18 minutes, and the longest, 75 minutes. Participants appeared very conscious of time and on several occasions interviews were cut short due to participant work commitments – usually patient visits. Health staff interviews had to be scheduled at least a week in advance to allow rescheduling of clinics and appointments. More cancellations/postponements were obtained from health staff (11%) compared to social work staff (3%) and health participants were less likely to schedule new appointments.

Social Work staff were generally more easily available and interviews were not restricted to particular periods within the working day. Interview duration lasted on average 50 minutes with the shortest being 25 minutes and the longest 125 minutes. Staff in general were less conscious of time and if interviews were postponed, participants quickly rescheduled. Interviews were generally scheduled with shorter notice and staff appeared able to accommodate interview times easier than their health colleagues. Managing time appeared to be more at the discretion of the social worker, whereas the health care worker was restricted by set daily routines, essential scheduled interventions and visits. As a result health care workers' diaries were less flexible or open to practitioner management than in social work.

### **5.5.3 Observed Interviewee 'Ease'**

Discernible differences were noted between health and social workers' reception of the interview. Social work staff appeared more comfortable with one to one 'interviews' and were observably more relaxed about discussing, thinking aloud, reasoning and reflecting. Interviews were therefore longer on average. Health staff often made the assumption that interviews would involve themselves and colleagues simultaneously, and on several occasions offered the participation of others in the interview. Although this offer was always declined by the interviewer, and the need to discuss individual perceptions reiterated, there was a sense that some health staff would have been more comfortable discussing issues in a group setting as opposed to one to one.

One explanation for these differences might be found in organisational management structures. Social work services operate regular supervision sessions whereby practitioners discuss cases with line managers and reflect on information received, services accessed, and the justification of decision-making. Such supervision is managed on a one to one basis although group sessions do occur to allow for the dissemination of relevant information. Reflective practice is therefore commonplace within social work services whereas health staff operate on a more autonomous basis - each member of the team is responsible for their own caseload and little 'formal' discussion takes place to reflect on practice issues.

The use of vignettes during an interview appeared less of a new concept to social work staff. On several cases health staff treated the interview as a test, and were more inclined to describe an ideal, textbook response. Health interviewees therefore required more prompting to maintain 'real world responses' and more effort was required on the part of the interviewer to reassure health interviewees that the subject matter was not an examination.

#### **5.5.4 Response to Qualitative Interview Methodology using Vignettes**

Care was taken to ensure the vignette was realistic and relevant to the practitioners interviewed. The majority of respondents recognised the characteristics of the scenario described within the sequenced vignettes and could relate them to current or previous cases. Responses to questions asked following the vignette presentation sometimes involved reflection on how similar situations were handled. An interesting and frequent observation was the manner in which the couple described in the vignette were 'incarnated' or 'animated' and became described by the interviewee in very realistic, real-time language. This phenomenon occurred more often during interviews with social work staff who often attributed characteristics, concerns and scenarios to the couple which were not described in the limited text provided. As the situation depicted in the vignette deteriorated, interviewees responded in protective, caring language. Some became very animated about the level of support required and displayed frustration at the inadequacy of services to respond following their initial observations. This perceived adoption of the couple as a real case supports the external validity of the vignette itself, but also reflects a professional tendency to generalise cases utilising knowledge of past experiences and predictable progress and outcomes.

#### **5.5.5 Response to the Vignette Related Questions**

Health staff were often more definitive in their responses to questions about needs identified during the vignettes, and actions to be taken. Needs were often listed using less narrative than their social work counterparts. Proposed actions taken were frequently directly related to the needs identified and often a 'problem and solution' scenario was described by health staff. Social work staff were less prescriptive when describing needs. In some cases workers were reluctant to identify need, but instead described the process by which needs were explored with the client. Responses from social work staff were frequently longer and were often punctuated with examples from practice: this rarely happened

during nurse interviews. Similarly social work staff were less inclined to relate particular needs to particular service solutions - many variables were described as precursors to identifying outcomes for clients.

## **5.6 Chapter Conclusions**

The recruitment phase of the study ensured that an adequate cross section of staff were interviewed. Themes emerged during the course of interviews and the sample size was limited to a point where saturation appeared to be reached i.e. no new themes were generated. The study itself became an iterative process with the author reflecting on responses and ensuring opportunities for subsequent exploration.

The next chapters consider the results of the study, analyse the findings and (where appropriate) relate these to the themes identified during the literature review.

## **CHAPTER SIX**

### **6 NEEDS IDENTIFIED FROM QUALITATIVE INTERVIEW METHODOLOGY USING VIGNETTES**

#### **6.1 Chapter Introduction**

This chapter aims to present the results elicited from study interviews. Consideration will be given to the components of need as they were identified by participants in relation to the sequenced vignettes and where appropriate comparisons will be made between professional groups. This chapter sets the scene for more detailed analysis of factors considered influential in the needs assessment process including decision-making, definitions, models of approach and organisational values.

Responses to Vignettes 1 and 2 will be considered in tandem and compared to those presented by the GSG. Differences will be highlighted where they were apparent during data analysis.

#### **6.2 General Overview of Responses Identified Between Professional Groups for Vignettes 1 and 2**

There was a relative degree of consistency across professional groups. The areas of mental health, urinary incontinence, housing and carer's needs were consistently highlighted by interviewees as of particular concern in response to the question, 'what needs do you think exist?' Whilst coding the data, language used by interviewees was retained to reflect their responses. These ranged from descriptions of 'areas of need' to 'investigations' and/or 'interventions required'. At this point in the interview process, the interviewee had not been asked to describe what actions would be taken in order to address needs. Despite this the majority of interviewees volunteered a list of actions and interventions which would be undertaken in the process of identifying and addressing

needs. Some were therefore unsure how to respond when later asked, 'what would you do in order to address these needs?' For some the notion of identifying needs and not relating this to some extent with resource intervention was an unfamiliar concept.

Having applied a needs-led assessment approach to Vignette 1, interviewees progressed these concepts in Vignette 2. As needs had escalated, respondents were asked the same questions within the semi-structured questionnaire and similar observations were made regarding the terms and processes by which needs were identified and described.

Familiarity with the vignette including knowledge of the deterioration meant that interviewees appeared to relate more easily and effortlessly with the situation. Many interviewees acknowledged a sense of reality and inevitability about the situation and in some cases launched, unprompted into the identification of needs.

Whilst needs were identified for Vignette 2 within the same categories as Vignette 1, the detail provided was lessened and the focus on outcomes appeared to be heightened. It is the author's opinion that interviewees, having just described in great detail the needs and actions required following Vignette 1, failed to reiterate recurring actions.

Vignette 2, unlike Vignette 1 appeared to be perceived and described as an entire entity as opposed to a set of specific needs: interviewees required more prompting to specify needs. In general respondents seemed to debate verbally, the capacity to maintain the situation within the community. Whilst interviewees did, with prompting, unpick needs and consider community-based services; others relegated the situation to the confines of institutional care. This debate was more evident amongst health staff, although social work staff did sometimes cite permanent care as an option to address needs.

Deconstructing needs, for some interviewees, appeared to facilitate the decision to identify permanent care as the most feasible option. The



perceived overwhelming nature of needs, the incapacity of community-based services to respond, and concerns over informal care appeared to support the identification of institutional care as the need and outcome.

The nature in which needs and choices were described not only reflected perceptions of care but began to raise issues about professional decision-making in relation to client/carer preference. Similarly consideration of future needs in light of current presentation was identified as having an impact on the proposed outcomes.

Interviewees were asked to consider each vignette as if this was the first presentation however it appeared difficult for them to disregard previous information. Within the following section of this chapter, comparisons will be made between professional groups. Similarly comparisons are made against the GSG responses identified for each vignette.

Vignette 2, on presentation led, to the identification of needs within the same categories as Vignette 1. Likewise when compared against the GSG responses, similar areas of need were identified:

- Mental Health (including mood and cognitive state)
- Urinary Incontinence
- Personal Hygiene
- Housing (including housecare)
- Mobility
- Social Isolation
- Carer's Needs

Figure 3 outlines the overall areas of need identified in response to the question, 'what needs do you think exist?' Numbers relate to the number of instances areas of need were volunteered during interview: this applies for all figures presented for this study.

Area of Need	Total Numbers Identified for Vignette 2	Total Numbers Identified for Vignette 1
Carer Needs	83	88
Mental Health	69	81
Personal Hygiene	63	83
Urinary Incontinence	62	96
Mobility	61	45
Housing	45	88
Socialisation	40	62
Financial	22	41

**Figure 3 Total Number of Responses to Needs Identified from Vignette 2 compared to Vignette 1**

The factors identified following presentation of Vignette 1 as being routine aspects of any assessment were highlighted less frequently in relation to Vignette 2 as Figure 3 illustrates. Jean's mental health and mobility had deteriorated and there was clearly an increase in the number of times mobility was cited as a need. The issue of carer's needs became the main area of focus rather than the presenting needs of the primary client which up until then was identified as Jean. This sentiment was initially noted in the responses provided by the GSG whose attention, when confronted with Vignette 2, was shared more equally between Jean and Bob, whereas Vignette 1 identified Jean as the main client and Bob as the carer.

The manner in which needs were described was suggestive of the conscious and subconscious thought processes and decision-making activity which underpins the assessment of need. An observation made during interviews was that the worse the scenario, the easier it appeared to be for assessors to identify need. The majority of assessors were quick to define the issues and responses required, and by Vignette 2, interviewees were more definitive in describing what the perceived issues were and what subsequent actions were required.

One might argue that familiarity with this couple, their situation and progression might ease the process of identifying needs: such knowledge might inspire confidence in making responses. Similarly familiarity with the study methodology and an understanding of the questions to follow might cause individuals to pre-empt answers and again might explain the slight difference in response. Lastly the stage the couple are at by Vignette 2 might reflect similarities with the assessors' caseload and therefore responses could be determined by experience of familiar, similar scenarios. As one nurse described,

"This is exactly the type of referrals we tend to get which is quite frustrating and annoying, whereas if you could intervene at the first stage then you could hopefully help" (N004)

This was a sentiment expressed by many interviewees across the professional groups. The sense of frustration yet inevitability underpinned many responses and raised issues about the timing of referrals, allocation, organisational prioritisation and an inability to cure versus care, or prevent versus react.

The next sections deconstruct each of the areas of need identified beginning with the most commonly cited.

### **6.3 Carer Needs**

Figure 4 illustrates that by Vignette 2, the client's needs appeared to have been overtaken by the carer's needs including the carer's need for advice and support and, most prevalently a break. The issue of sleep deprivation was raised as a new concern and was referred to by interviewees.

Area of Need	Total Numbers Identified for Vignette 2	Total Numbers Identified for Vignette 1
Break	62	39
Respite	59	23
Sleep Deprivation	36	0
Support	33	33
Day-care	16	20
Befriender	14	12
Carer assessment	13	26
Arthritis	9	67
Advice & info	7	18

**Figure 4 Total Number of Needs Identified with Carer's Needs in Relation to Vignette 2 Compared to Vignette 1**

The short or long-term nature of a break was identified as day care or befriending whereas respite care constituted a longer term break. The general impression was that the carer required respite care although this was often quoted alongside his need for regular short breaks. Day care, where cited, most frequently related to Jean attending a day care facility with a few assessors indicating that the carer might benefit from attending some form of day care.

In Vignette 1 interviewees often identified arthritis as a carer-related need however, armed with the knowledge that Bob was now sleeping poorly, the issue of sleep deprivation was occasionally cited. The gravity of sleep deprivation on the carer's health and ability to cope was undisputed by most interviewees who at times volunteered this as critical to the quality and sustainability of care provided. Social workers identified the need for a break in the form of respite care more so than nursing staff.

It was also noted that identification of client and carer's needs occurred simultaneously during the majority of interviews. The overall assessment of the situation included the carer who, by Vignette 2, appeared to emerge as a client in his own right. Assessment of the carer's needs was highlighted by a few interviewees as a requirement. The extent to which carer's assessments were undertaken by organisations appeared limited. In some instances assessment of the carer's needs occurred more formally when the carer became a client of the professional interviewed. In such cases the assessment undertaken followed a similar process as his wife's and focussed on his own general needs and not those specific to caring. As the carer was ageing and suffering from a progressive illness, this might explain the need to assess his needs as a client as opposed to a carer. His ability to care was often described as subject to his own health needs and the capacity of services to respond appropriately to his wife's needs. The duality and connectivity of needs appeared to determine the assessment undertaken and the actions initiated.

The GSG applied the same criteria to Vignette 2 as they did to Vignette 1 which involved the following areas (for comparison):

- Consider support provided by informal carer
- Identify any difficulties experienced by carer in relation to his own health needs and the impact of caring for his wife
- Consider carer's willingness and ability to continue providing support for his wife
- Consider carer's preferences for support and service intervention
- Consider carer stress levels
- Consider the carer's need for a break (short and long-term, temporary and permanent)
- Consider carer's awareness of support including availability and access
- Identify any additional support provided by other informal carers
- Ensure a carer's assessment is carried out
- Ensure a financial assessment is carried out with the carer and that all benefits are maximised

The extent to which the carer was able to care, desired to care and required assistance to care was considered by both the GSG and the study group. The description of needs and actions varied with the study group identifying specific areas of concern such as sleep deprivation, and service intervention such as respite care. The method of arriving at these conclusions was made explicit in the GSG responses which detailed the considerations which determine interventions whereas the study group were asked to consider needs and then to detail how needs were identified.

The role of informal care cannot be underestimated as indicated in the literature review. Informal contributions to care are difficult to categorise and quantify therefore they often go unrecognised. The role of anticipatory care, prompting, supervision, physical assistance encompass daily activities for many informal carers however interventions are not easily deconstructed and represented on assessment recording tools. From the study results, little emphasis was given to separate assessments specific to carers despite professional acknowledgement of their invaluable contribution.

## **6.4 Mental Health**

By Vignette 2 Jean had become depressed and this, alongside the dementia, was raised as a need by the majority of the respondents. The cause of this need was speculated by some as being associated with the progression of the dementia and social isolation caused by deteriorating mobility. The need for a specialist assessment continued to be alluded to as indicated in Figure 5. Subsequently the need to establish the diagnosis of both dementia and depression was often repeated and included references to the GP and Consultant more frequently than in Vignette 1. Less detail was volunteered about specific aspects such as the MMSE and memory clinic.

<b>Area of Need</b>	<b>Total Numbers Identified for Vignette 2</b>	<b>Total Numbers Identified for Vignette 1</b>
Dementia	65	81
Depression	60	0
Consultant	36	29
Medication	34	23
Specialist Assessment	26	31
GP	22	21
Establish Diagnosis	16	23
CPN	11	16
Memory Clinic	0	6
MMSE	0	6

**Figure 5 Total Number of Needs Identified with Mental Health in Relation to Vignette 2 compared to Vignette 1**

The main information volunteered by the interviewees involved investigations, specialist assessments and actions required. Whilst assessors identified the need to establish the diagnosis, there appeared to be discrepancies about whose responsibility it was to identify, address and manage this. Community nurses identified professionals other than themselves as best placed to deal with the needs.

“Her needs would be better addressed by social services and CPN involvement rather than district nursing” (N038)

Of all the professional groups interviewed, social workers rarely questioned their role in assessing, coordinating and addressing needs but often highlighted the requirement to collate these responsibilities through the contributions of other professional groups.

“I would see myself as managing that case and having contact with other people even though not directly providing the services” (SW004)

The complex nature of mental health needs was also highlighted by the GSG who listed a comprehensive catalogue of actions, interventions and investigations including:

- Cognitive assessment e.g. MMSE by health professional
- Assess level of depressed mood
- Identify potential cause/s of depressed mood
- Referral to GP or Consultant for physical and mental health assessment to eliminate acute confusion and/or depression as a cause of memory loss
- Establish a history of cognitive decline
- Establish a history of depressed mood including initiating factors if identifiable
- Consider compliance with medication – poor compliance may precipitate decline in mood and cognitive state
- Gather information from appropriate agencies
- Discuss with the client her thoughts regarding cognitive decline and depressed mood
- Consider the use of medication to manage cognitive decline and depressed mood
- Consider client's ability to make informed choices about her needs and the support she receives

The GSG clearly focussed on the need to establish diagnosis including: history, causation, presentation and management. The study sample group identified the need for specialist assessment although the specialist was not always identified. Study results highlight a general consensus that diagnosis and management were important to the assessment of need. Need was so closely linked with these two components that it was rarely described in the absence of a 'need for' statement which then described as investigation and/or intervention. The detail provided by the GSG was rarely replicated during interviews within the course of the study, although the general areas described such as identification of degree of depressed mood, cognitive impairment, potential causes and investigative referrals were frequently cited by respondents. The



consideration of medication as a potential cause or treatment was not routinely described by interviewees, many of whom appeared to deliberately refrain from reaching for medicinal remedies.

## 6.5 Urinary Incontinence

Responses to urinary incontinence appeared to change on presentation of Vignette 2. Jean had become incontinent of urine overnight and there were concerns she may fall on her way to the bathroom. Whilst urinary incontinence was the most commonly identified need in Vignette 1 it was mentioned less frequently in relation to Vignette 2. Figure 6 outlines the number of times needs associated with urinary incontinence were mentioned in response to Vignette 1 compared to Vignette 2.

Area of Need	Total Numbers Identified for Vignette 2	Total Numbers Identified for Vignette 1
Garments	27	36
Commode	22	6
Continence Services	20	58
Investigation	16	42
District Nurse	13	28
Laundry	10	4
Homecare	5	0
Infection	4	10
GP	3	14
MSSU	3	10
Education	1	8

**Figure 6 Total Number of Needs Identified with Urinary Incontinence in Relation to Vignette 2 Compared to Vignette 1**

In terms of the proportionate response, social work staff continued to favour the introduction of Continence Services whilst nursing staff focussed more on the provision of equipment and garments (continence

pads, pants, bedding). Direct access to particular services or equipment might explain the difference, with some nurses assuming the responsibility to assess and manage the continence needs identified.

The opportunity for health staff to utilise specific skills, meet needs personally or access specialist services was particularly evident from the way needs were described. Social workers, whilst demonstrating an understanding of the issues experienced as a result of urinary incontinence, identified the need to refer onto another professional or agency in order to address the need.

Health staff identified issues over causation and the requirement to investigate, however continence management, for all professional groups appeared to be an overriding concern. This stretched to some of the consequences associated with overnight incontinence such as excess laundry and the need for assistance with homecare.

Needs were rarely identified in isolation: in many instances needs were highlighted in terms of how one impacted upon another. The effects that urinary incontinence exert on increasing carer stress, the impact of deteriorating cognition on the ability to educate, advise, rehabilitate are examples of the interwoven nature of complex needs and the requirement for a holistic approach to assessment. This was highlighted in the response provided by the GSG who considered the following areas and actions in relation to urinary incontinence:

- Collect MSSU
- Visit client at home
- Establish cause of urinary incontinence
- Identify client's level of insight into incontinence and discuss her desire for treatment/investigation/management
- Provide pads and pants if required
- Referral to GP or Nurse Specialist for specialist assessment
- Contact health visitor, continence nurse specialist or physiotherapist depending on cause

- Assess diet and fluid intake (particularly in evenings)
- Consider daily routines including visits to the bathroom
- Check compliance with existing continence garments
- Facilitate treatment of cause if appropriate
- Check past medical history involving medical record and laboratory results
- Assess home situation e.g. access to toilet
- Assess client's mobility
- Contact other relevant agencies already involved to ascertain history on progress

Responses offered in relation to Vignette 2 were almost exactly the same as those provided by the GSG, with the exception of 'consider daily routines including visits to the bathroom'. The need to establish causation was replicated in the study group who also considered equipment interventions such as the provision of a commode: the GSG on the other hand, appeared to focus more on the investigative stage of the assessment and only considered 'pads and pants' as potential interventions.

## 6.6 Personal Hygiene

Vignette 2 explicitly described deterioration in Jean's personal hygiene including an inability to get in and out of the bath. Figure 7 outlines the numbers within the study group who indicated particular components as needs compared to Vignette 1.

Area of Need	Total Numbers Identified for Vignette 2	Total Numbers Identified for Vignette 1
Bathing	49	84
Personal care services	37	27
Aids & Adaptations	21	42
Homecare	21	18

Area of Need	Total Numbers Identified for Vignette 2	Total Numbers Identified for Vignette 1
O.T	17	62
Dressing	17	6
Washing	16	8
Walk-in Shower	9	0
District Nurse	8	3
Skincare	4	10

**Figure 7 Total Number of Needs Identified with Personal Hygiene in Relation to Vignette 2 Compared to Vignette 1**

When asked 'what needs do you think exist?' the responses were fairly similar between professional groups and in comparison to Vignette 1.

Bathing was clearly identified by interviewees as a need however discussion extended to other areas of personal care including washing and dressing. The perceived professional need for personal care services remained high however the role of the district nurse appeared to be heightened. The services of the O.T and the provision of aids and adaptations were cited less frequently by interviewees by Vignette 2 despite the mention specifically of a walk-in shower by a few respondents when asked about needs. Attention appeared to focus on the management of needs which, as well as requiring equipment now appeared to require physical assistance too.

Skincare remained an issue although continued to be expressed by a small number of individuals from the professional groups. Of the social work staff who identified skincare as an issue, it was described as something to be aware of but outwith their professional capacity. Where it was identified, the outcomes always involved a referral onto whoever was considered the most appropriate agency.

The GSG on the other hand identified skin integrity early on in the assessment process. Their responses in terms of actions in relation to Vignette 2 were identical to those offered after Vignette 1 i.e.:

- Consider skin integrity
- Consider client's ability to wash and bathe
- Identify client's wishes/preferences regarding support to wash and/or bathe
- Consider the bathroom facilities: access to sink and into bath
- Refer to OT for assessment for bathing equipment and possibly adaptations
- Consider client's ability (mentally and physically) to bathe using equipment
- Consider support provided by formal and informal carers (actual and potential)

Like previous GSG responses, the requirement to establish the client and carer's views in relation to professionally perceived need and potential interventions was identified. Client and carer preference and cooperation were considered important aspects within the study group. These components were carefully deconstructed following more in depth discussion and will be explored in Chapter 7, 8 and 9.

## **6.7 Mobility**

Little was said of mobility in Vignette 1 however by Vignette 2 Jean's mobility had deteriorated and she had experienced several falls. Figure 8 identifies the number of times components of need were mentioned in relation to mobility.

Area of Need	Total Numbers Identified for Vignette 2	Total Numbers Identified for Vignette 1
Falls	54	3
Specialist Assessment	27	7
Equipment	20	17
O.T	11	13
Physiotherapy	7	11
Walking frame	6	4
Wheelchair	6	1
GP	5	3
Cotside	2	0

**Figure 8 Total Number of Needs Identified with Mobility in Relation to Vignette 2 Compared to Vignette 1**

Whilst the O.T continued to be identified in relation to mobility, the numbers of professionals suggesting the physiotherapist reduced slightly. The provision of equipment including, in some cases, cotsides continued to be expressed.

A noticeable difference between the two vignettes was the urgency with which needs were highlighted. The introduction of falls to the scenario caused more reference to this as an area of need and appeared to heighten safety concerns.

The connectivity of one area of need to another continued to be expressed. The ability of an individual to function independently was discussed by several respondents and was alluded to more frequently as independence and functioning declined. Any factors which appeared to compromise independent functioning were often considered with respect to internal or external capacity. One model adopted by a social worker was applied to Vignette 2,

“Needs broadly speaking come in two bands: resources and risks. Because he is beginning to fail in a physical sense then the risks and the resources that they have available to them change: the risks go up and the resources go down” (SW018)

The GSG only mentioned mobility as a specific category of need when presented with Vignette 2. Mobility was considered a component of other aspects of need within Vignette 1 such as urinary incontinence and social isolation however in relation to Vignette 2; the GSG raised the following requirements:

- Refer to GP for investigation of cause of falls
- Ensure full physical health check is carried out
- Refer to physiotherapist for a full mobility assessment and provision of equipment and/or rehabilitation if considered appropriate
- Provide equipment and consider adaptations to home to ensure mobility is maintained at an optimum
- Refer to O.T for an assessment of ability to manage within current accommodation

The requirement for specialist investigations was undisputed by both the GSG and the study group however the physiotherapist was identified by the GSG as the professional of choice to assess and provide equipment or rehabilitation. Rarely was this the case in the study group where referrals were generally made to the O.T. The combination of medical and physical health problems as a cause of decreased mobility was rarely discussed by interviewees during the study but was highlighted as an action by the GSG. In contrast the study group tended to specify types of equipment whereas the GSG referred to ‘equipment’ in general.

## **6.8 Housing**

The identification of needs and mechanisms for meeting these in relation to housing was very different for Vignettes 1 and 2. In Vignette 1 the

need to rehouse featured more prevalently: by Vignette 2 this appeared to have been abandoned in favour of addressing specific concerns suggested around housecare in particular. This appeared to be based upon the supposition that community care was the agreed environment in which needs would be met despite the fact that not all assessors interviewed were convinced that community care would be effective or responsive enough to meet the needs identified. Figure 9 identifies the numbers of responses made in relation to needs associated with Vignette 2 compared to Vignette 1 and reflects the consideration of domestic tasks and interventions in order to support safe living within the community.

Area of Need	Total Numbers Identified for Vignette 2	Total Numbers Identified for Vignette 1
	2	1
Housecare	56	23
Rehousing	13	55
Cooking	12	26
Shopping	8	29
Alert Alarm	4	1
Lift	2	26
O.T	2	10
Adaptations	0	13

**Figure 9 Total Number of Needs Identified with Housing in Relation to Vignette 2 Compared to Vignette 1**

No information was provided in the Vignette about the couple's ability to manage housecare, shopping and cooking; therefore references to those areas by interviewees were as a result of the application of their own assessment skills. It appeared to be based largely on experience of similar situations and the likelihood of these types of needs existing within complex cases. Social work staff were more concerned about issues over housecare, cooking and shopping compared to health staff who in general made less reference to housing as an issue.



Social work staff more so than any other professional group identified the need to consider rehousing. Specific reference was sometimes made to the lift and concerns raised were this to fail. Only those professionals from housing, however highlighted the fact that the lift would not reach the top floor but would stop at the floor below, requiring the couple to manage a flight of stairs. The perception of the home environment and the relevance of professional background were highlighted by one housing professional:

“We are very much about property: the bricks and mortar because that’s our culture. We look at the housing; we look at the four walls around the person. And then we start to think about what we can do about those four walls rather than what we can do for the person”  
(H003)

For many there was a dichotomy between retaining familiar surroundings for someone suffering from dementia whilst ensuring safety and ability to socialise. Despite this professional dilemma a high proportion of staff, particularly within social work, considered rehousing as an option: often the caveat was added that as a result of waiting times for rehousing, there was value in making an early referral for rehousing: the supposition being that by the time the resource became available, the progressive nature of the illness coupled with the ageing process, would mean that the need for rehousing would be more imminent and appropriate.

The GSG only considered housing issues in relation to Vignette 2 and these focussed more on establishing the following:

- Consider suitability of housing
- Identify client and carer’s wishes with regards to continuing to live in current accommodation and option to consider alternative housing
- Identify specific issues relating to difficulty with housecare and subsequent areas e.g. shopping, collecting pension

- Ensure a benefits check has been carried out and benefits maximised
- Consider support currently provided within the house by both formal and informal carers
- Identify preferences and wishes of both client and carer with regard to receiving support to maintain the house
- Refer to O.T for an assessment of ability to manage within current accommodation
- Consider physical safety hazards within the home

Whilst some references were made by the GSG regarding the potential to rehouse and the role of home care services in meeting particular domestic needs, the overall approach taken to this situation was more general than that undertaken by the study group. The study group considered more specifically the components of need within a domestic setting. The GSG used needs associated with housing to consider financial needs which were categorised separately in relation to the study group.

## 6.9 Socialisation

With respect to the trends identified around socialisation, little change was identified between Vignettes 1 and 2, with socialisation featuring amongst the bottom three need categories identified. Like all categories of need, less reference was made to areas of socialisation for Vignette 2 however the trends appear to persist as Figure 10 illustrates.

Area of Need	Total Numbers Identified for Vignette 2	Total Numbers Identified for Vignette 1
Day-care	21	40
Befriending	10	33
Club	2	9

**Figure 10 Total Number of Needs Identified with Socialisation in Relation to Vignette 2 Compared to Vignette 1**

More social workers than health workers identified specific interventions such as day-care and befriending, whilst nurses were more likely to mention a club as a means of providing social stimulation. Social isolation was often cited as a potential cause of depressed mood. Interviewees offered few suggestions in response to this need other than those highlighted above.

Day care services continued to be favoured above domiciliary services such as befriending however its place in meeting clients' socialisation needs was not always uncontested. Service limitations were highlighted in relation to the availability and suitability of day care by many interviewees from professional groups. The pressures and frustrations this placed on clients, professionals and organisations inevitably led to alternative resources being considered. One CPN candidly explained how she would have to deal with this dilemma,

"If this lady couldn't get into day care I would say 'she needs assessed for her dementia', and I'd get her into the day hospital because you can get them in there quicker: she wouldn't really need to go to the day hospital - but you would maybe invent a reason for her to go so that Bob is getting some respite" (CPN09)

The GSG adopted a different approach to the responses/actions required in relation to the needs associated with social isolation. These remained the same as the responses offered for Vignette 1 and focussed on establishing the cause and nature of the social isolation alongside general attitudes towards accessible, available services:

- Consider whether client considers themselves socially isolated
- Consider client's personality and wishes/preferences for social stimulation
- Consider client's ability (mental and physical) to engage in social activities
- Consider structural and environmental issues including ease of access in and from the building

- Consider client's awareness of available resources and desire to use them
- Consider accessibility of available resources
- Consider mental health issues e.g. client may be depressed or anxious about socialising
- Consider safety of area outwith the flat e.g. there may be a high crime rate
- Consider orientation to time and place
- Consider client's social circumstances and past social history
- Contact local agencies already involved

Unlike the GSG, the study group focussed on specific interventions to alleviate the client's needs. Day-care as a form of short-term respite was also frequently identified by the study group in relation to the carer's needs.

## 6.10 Financial

In response to Vignette 2 similar financial needs were identified compared to Vignette 1. As with other areas of need, finances were mentioned less frequently although the requirement for a benefit check remained uppermost in people's descriptions. Figure 11 outlines the numbers of responses made in relation to categories of need for Vignette 2 compared to Vignette 1.

Area of Need	Total Numbers Identified for Vignette 2	Total Numbers Identified for Vignette 1
Benefit Check	16	38
Benefit Maximisation	8	24
Collect Pension	3	9

**Figure 11 Total Number of Needs Identified with Financial Matters in Relation to Vignette 2 Compared to Vignette 1**

Nursing staff slightly more so than social work staff identified the need for a benefit check in Vignette 1 however where social work staff identified this as a need, this was almost always followed by the need for benefit maximisation. In many cases social work staff undertook the benefit check and maximisation as a routine part of any assessment. Social work staff continued to identify benefit maximisation in tandem with a benefit check for Vignette 2 however nursing staff hardly raised or discussed benefit maximisation following Vignette 2. Benefit maximisation was not an area identified specifically by the GSG.

As identified earlier, benefit maximisation was described by most social workers as a routine component of their assessment and provided clients with a greater choice of services. The sensitivity associated with considering in detail an individual's financial income was identified by some health staff as potentially detrimental to the therapeutic nature of the patient/professional relationship. Several health staff found the process intrusive and sought to avoid it.

The degree to which Vignette 2 was considered manageable within the community could influence the importance afforded to financial matters. One social worker summed up her perception of the situation,

“When it reaches a state of crisis, resources and finances come less into play: getting the crisis dealt with is more important” (SW010)

The focus on needs and outcomes witnessed in response to Vignette 2 as opposed to the specific methods of identifying those needs and arriving at those outcomes (as witnessed in Vignette 1) could be explained by the extent to which the situation was considered a crisis.

### 6.11 General Observations of How Needs were Described

In terms of responding to the question 'what needs do you think exist?' interviewees used similar descriptions for Vignettes 1 and 2. Figure 12 identifies the responses identified.

Area of Need	Total Numbers Identified for Vignette 2	Total Numbers Identified for Vignette 1
	2	1
Assessment & investigation	61	81
Service intervention	53	64
Resource referral	40	56
General questions asked	21	49
Chase referrals	15	0
Support	11	14
Problems	8	14
Areas of need	6	15
Social & Nursing	0	9

**Figure 12 How Needs were Described in Relation to Vignette 2 Compared to Vignette 1**

Needs were often described as a need for assessment, investigation or service intervention: rarely were needs described as symptoms or issues specific to the conditions experienced by the scenario subjects. For example where dementia, incontinence and mobility were identified, the context for describing these as needs involved explaining the activities undertaken by the assessor to establish or confirm the need and to attempt to address the need. At this point in the interview respondents had not been asked how they would address needs although in most cases needs were described by the ways in which they would be addressed such as a need for a service intervention or resource referral.

In many cases, assessment and investigation were considered a service intervention in and of itself. For example management of incontinence issues, for many professionals triggered the description of a referral to a specialist continence service whose role was perceived by most referrers as assessment and management. Appropriate service or therapeutic interventions were often left to the discretion of others considered 'specialist' in particular fields such as mental health, continence, mobility. In the case of nursing staff, responses to the assessment often involved themselves as the specialist assessor and/or service provider. Their professional identity and credibility appeared to be dependent on their ability to address need as well as assess it,

"If you carry out an assessment and you want a positive response, you have to (a) interact with them properly, (b) respect their point of view and (c) prove you are able to resolve or at least assist to resolve or partially resolve some of the issues that they raise" (N017)

Not all interviewees used the term 'need' when responding to the initial question, 'what needs do you think exist?' For some the term 'issues' was favoured whilst others described 'problems' or 'difficulties'. Need was frequently quoted in descriptions by social work staff. Most responses described the actions required in order to attempt to address needs. Therefore the term 'a need for' was more frequently used than the term 'a need with'.

For some interviewees, the notion of explicitly commenting on need seemed to be avoided: instead the use of persistent questioning was used as a method of demonstrating how needs (or their equivalent) would be identified. This approach was evident in the Gold Standard responses where actions were identified as considerations. Study participants demonstrated the same questioning approach. When describing needs, the process of expressing some of the general questions asked of a client occurred less frequently in Vignette 2: interviewees were more definitive in their responses about what needs existed and what actions were

required. The assessment by this stage appeared to be more professionally driven and concentrated less on the reflective, enquiring, engaging aspects which were often identified (explicitly and implicitly) during discussions regarding Vignette 1.

The frequency with which descriptions of needs were identified and actions volunteered, differed very little from Vignette 1 to Vignette 2. This supports findings outlined in the literature review whereby needs were described in service terminology and reflected the outcome as opposed to the state of being. The need for service intervention, resource referral, assessment and investigation remained prominent in the study, although the latter was highlighted more by social work staff than nursing staff.

An additional area identified in relation to Vignette 2 was the need to 'chase' referrals. The notion that service referrals were made and services initiated as a consequence was disputed as unrealistic. Some interviewees identified the need to spend a significant proportion of their time chasing referrals and following up service requests.

### **6.12 Responses to the Comprehensive List of Services, Professionals, Aids and Adaptations**

During the development and pilot phase of the study a Comprehensive List of resource interventions was drafted. During the study each interviewee was asked to identify which services, professionals, aids and adaptations they considered appropriate by ticking them on the Comprehensive List. This was presented at the end of the interview and interviewees were asked to respond as if the client/s had reached the stage depicted in Vignette 2. This allowed the author to compare resource interventions volunteered with those identified from the Comprehensive List drafted by the GSG. As interviewees were asked to imagine that all the resources listed were available and easily accessible, this also allowed the author to consider the role resource awareness and availability might play on the assessment of need.



In total, the Comprehensive List contained 47 items covering the three areas of services, professionals, aids and adaptations. Of the resource interventions volunteered during interviews (i.e. before presentation of the Comprehensive List) a total of 114 items were identified across the sample: these included the majority of the 47 items from the wish list but extended to resources such as the concierge, assistive technology, voluntary agencies and some local services/projects. Clearly the Comprehensive List proved less comprehensive than the resources identified by the study sample, although it did serve to focus attention on the implications of greater and easier access to resources.

#### **6.12.1 Services Volunteered and those Identified from the Comprehensive List**

Consideration of the Comprehensive List of Services identified as appropriate, highlighted a high proportion of service interventions with community care, particularly those provided within or from the home, as favoured. Figure 13 illustrates the number of instances where assessors identified a particular service as appropriate by the stage depicted in Vignette 2.

<b>Services</b>	<b>Number of Times Identified</b>
Home Help	99
Specialist Day Care	95
Dementia Carers Support Group	94
Respite Care	92
Information Leaflets	85
Evening & Overnight Support	77
Dementia Sufferers Support Group	77
Home Befriender	70
Sheltered Housing	64
Meals on Wheels	60
Advocacy	50

Services	Number of Times Identified
General Day Care	48
Nursing Home Care	25
Hospital Care	22
Residential Care	20

**Figure 13 Services Identified from Comprehensive List by all Interviewees**

There was a great deal of similarity between professional groups. Home befriending was identified less often by nursing staff than social work as was the dementia sufferers' support group.

It is evident from the responses that access to community care services was generally favoured by professionals as opposed to residential or nursing home care. Few interviewees identified the need for hospital admission (with the exception of the two GPs interviewed). Amongst the most popular service choices were home helps, specialist day care, respite care, and dementia carers' support group. The less frequently identified services, other than nursing home, residential home or hospital care, were general day care and advocacy.

All professional groups identified more service interventions from the Comprehensive List than they had volunteered during the course of the vignette related interview. When presented with excess resource, needs appeared to increase. Those who considered the possibility of nursing or residential care (on a long-term basis), when presented with the vignettes, continued to identify it as a service need. Day-care responses reflected the fact that specialist dementia day-care placements did not exist therefore were not volunteered. With these exceptions most professionals, when presented with an extensive array of services, appeared to identify a need for them. In the words of one GP,

“The more you know is available, the more confident you are and the more that you can do” (GP001)

### 6.12.2 Professionals Volunteered and those Identified from the Comprehensive List

Figure 14 identifies the number of instances whereby interviewees identified professionals from the Comprehensive List as appropriate interventions following presentation of the Vignette sequence.

Professional	Number of Times Identified
Social Worker	96
OT	93
GP	93
Psychogeriatrician	86
Continence Facilitator	86
Welfare Benefits Officer	84
District Nurse	79
Alzheimer Scotland	79
Chemist	72
Chiropodist	71
CPN	61
Physiotherapist	56
Health Visitor	54
Geriatrician	35
Mental Health Officer	31
Counsellor	29
Practice Nurse	23

**Figure 14 Professionals Identified from Comprehensive List by all Interviewees**

Professionals identified as required from the Comprehensive List appeared similarly across professional groups. Of the few differences noted, the

physiotherapist and chemist were identified more often by nursing staff than social work staff. Slight differences were indicated in relation to the mental health officer (MHO) and the continence facilitator: nursing staff identified a need for the MHO more so than social work staff who in turn identified a need for the continence facilitator more so than nursing staff.

The most frequently identified professionals indicated by the study sample included the social worker, OT, psychogeriatrician, GP and continence facilitator. Whilst the district nurse was often identified as an appropriate professional, the incidence was less than the other groups identified above. Even less frequently highlighted were the health visitor and CPN. The least frequently identified professionals included the practice nurse, MHO, geriatrician and counsellor. This data would be enhanced with the inclusion of the perception of clients and carers deemed as requiring such professional intervention.

Comparison of professionals volunteered during interview and those chosen from the Comprehensive List suggested that in most cases more professionals were identified from the list than were volunteered during interview. The one notable exception was the O.T who appeared to be identified equally between the two. A few professionals failed to be identified during interview, but were identified on the Comprehensive List, as appropriate to the care of the client. The practice nurse, MHO, chiropodist, counsellor and chemist rarely if ever, were volunteered in the course of the interview, however when presented in the Comprehensive List, were considered required. Chiropody and the chemist were particularly marked by their absence during interview but identified from the Comprehensive List.

Some interviewees did suggest that the List served to remind them of services available to them: others used it as a wish list, suggesting that awareness and availability of services did influence the assessment of need and their ability to be needs-led. Where needs were defined and identified by the resources which could meet them, these results suggest that assessments of need are tailored to available and known resources

as opposed to interventions. The specificity of terms i.e. the type of resource as opposed to the type of intervention, as a study finding which supported that indicated from the review of the literature.

### **6.12.3 Aids and Adaptations Volunteered and those Identified from the Comprehensive List**

Figure 15 identifies the number of instances where the study group identified particular aids and adaptations from the Comprehensive List as appropriate responses following the Vignette sequence.

<b>Aids &amp; Adaptations</b>	<b>Number of Times Identified</b>
Bath aids	93
Incontinence pads	93
Community alert alarm	85
Smoke detector	85
Commode	80
Raised toilet seat	79
Dossett box	73
Walking frame	69
Fire guard	67
Isolation valve	64
Wheelchair	48
Walking stick	40
Glasses	35
Cotsides	31
Hearing aid	26

**Figure 15 Aids and Adaptations Identified from Comprehensive List by all Interviewees**

When presented with the Comprehensive List, there was general agreement between professional groups as to what was considered required. Bath aids and incontinence pads were identified frequently as

was a raised toilet seat, community alert alarm, smoke detector, commode and dossett box. Of those indicated less frequently: glasses, hearing aid and cotsides were listed.

Comparison of the aids and adaptations volunteered during interview and then from the Comprehensive List suggests a higher degree of discrepancy between the two approaches. Whilst bath aids and incontinence pads were frequently volunteered during interview, these were identified more frequently on presentation of the Comprehensive List. Access to explicitly named pieces of equipment, for some assessors might not be a reality in practice therefore was not considered or described explicitly during interview.

Vignettes 1 and 2 did not at any stage describe difficulties with vision or hearing yet some assessors still identified these from the Comprehensive List. Other pieces of equipment such as a smoke detector, fireguard, and community alert alarm could be considered preventative and/or standardised components of routine assessments therefore the probability of them being expressed in relation to specific scenarios could be considered less likely.

For most assessors the issue of resources including aids and adaptations was raised in relation to the lack of or difficulty in access to. When presented with a host of easily accessible resources, this part of the study did appear to suggest that the greater the resources, the greater the need or demand. The notion that resources influenced assessments was often contested by interviewees who in the main recognised the opportunity to be resource as opposed to needs-led but worked hard to counteract this temptation.

### 6.13 Actions Undertaken in Order to Address Identified Needs

Following presentation of each vignette, interviewees were asked the question, 'what would you do in order to address these needs?' As respondents had already described needs, many with reference to the actions they would undertake, some considered this question a duplication of the previous.

Despite the perceived duplication, the question was asked of every interviewee following presentation of each vignette. The categories identified were common to each vignette and incorporated general actions and specific interventions. Overall responses ranged from assessment (specialist or general) to service intervention (personally, directly or by referral) and included some of the roles adopted by particular practitioners during the course of addressing needs. Figure 16 outlines the references made to actions undertaken by the study group:

Actions Taken in Order to Meet Needs	Frequency of Responses by Professional Group following Vignettes 1 & 2				
	Nursing	SW	Housing	CPN	GP
Resource referrals	38	42	5	10	2
Refer for specialist assessment	28	31	4	6	2
Provide service options, advice	16	42	0	4	0
Client compliance	20	21	2	4	2
Meet needs personally	15	12	1	6	0
Refer for general assessment	22	6	1	4	1
Pursue service providers	16	12	0	5	0
Review regularly	16	8	0	1	1

Actions Taken in Order to Meet Needs	Frequency of Responses by Professional Group following Vignettes 1 & 2				
	Nursing	SW	Housing	CPN	GP
Service access	12	6	0	5	1
Care manage	3	13	0	3	0
Incremental approach	11	7	0	1	0
Create care plan	7	8	0	3	0
Counselling	0	10	0	0	0
Advocacy	1	3	0	0	0

**Figure 16 Actions Taken in Order to Meet Needs following presentation of Vignettes 1 and 2**

The most frequently identified action was the referral for resources followed by referral for specialist assessment. Provision of service options was also identified regularly as was the consideration of client compliance. Actions undertaken in order to establish need and then to address that need were identified by the study group in general. Whilst some assessors identified their skills, roles and responsibilities in meeting needs personally, few identified interventions such as counselling and advocacy.

The majority of respondents identified 'resource referral' as the most frequent action undertaken. This appeared to occur in similar degrees across professional groups. Following resource referrals, 'referral for specialist assessment' was the next most cited action undertaken and again appeared to occur in similar degrees across professional groups. Connections between a specialist assessment and a resource referral were often highlighted with access to resources via referral, dependent on subsequent specialist assessments.

The 'provision of service options and advice', despite being the third most cited action was identified disproportionately across professional groups. There was a higher relative percentage of social work staff who identified this as an action following assessment, compared to nursing staff,



“At the end of the day it is for the client to decide: I think our job is to inform them about all the possible options open to them and then they can decide what to do. The thing is resources are limited and you do try to be as needs-led as possible. Moreso we have to listen to the clients and their family and let them speak “(SW027)

Establishing client compliance and preference with regard to addressing need was identified uniformly across professional groups and was also raised as an issue in response to other vignette questions including, ‘how do you identify needs?’ and ‘what factors influence the extent to which you are able to address needs?’.

Nursing staff appeared to ‘refer for a general assessment’ moreso than social work staff. For many, the general assessment was expected to be carried out by social work staff who rarely contested the relevance of their professional input. Only a few social workers identified the need for a general assessment by another professional agency: where this occurred there was some debate over what constituted a specialist assessment and a general assessment.

Referral to social work services for assessment by other professional groups raised issues about perceived roles and responsibilities and capacity to effectively address needs directly. For several interviewees the need to refer to social work for a general assessment was due to their perceived role and authority to access resources funded by Local Authorities.

“Nurses often pass cases over to social work because they see it as a social work responsibility to provide certain services or to assess need. They do it because they cannot access the resources they think are required. Whether social work provide the services or not is open to question but it then moves the responsibility out of the health service remit” (SW045)

The relationship between professional groups and professionals and their clients has the potential to be influenced by the assessment process and ability to address needs identified during this process. The complications connected with assessors (specialist or generic) having responsibility to assess needs and access or directly provide resources was often identified,

“I don't believe assessors should be providers because if you are a provider and you have got finances or resources attached to what you do then you are not going to go out there just assess from a purely needs-led perspective” (N010)

Despite the expressed conflict of interest identified by the role of assessor and service provider, the need to action an assessment was a concept frequently reiterated by the actions and descriptions expressed by interviewees. Needs were rarely described without reference to resource referral, service intervention and investigation. The urge to respond meant that no assessor described needs devoid of a professional response.

Having identified and referred or accessed a particular resource, the need to pursue service providers and/or review regularly was identified consistently across professional groups. Perhaps this was fuelled by the restrictions and limitations already alluded to by several professionals. In some cases needs were addressed by the assessing professional: nurses often described direct interventions in relation to continence management: social workers often described their role in counselling, advising and care management. Again the perceived professional responsibilities in assessing and addressing needs emerged in relation to continuing professional involvement. Some social work staff described health (in particular nursing) staff as disengaging from situations where their professional expertise and authority was considered redundant,

“I think one of the differences between health and social work is that health, if something is offered and if it's not followed up on - if the

individual rejects the service - there's never any attempt to re-engage it. It's as if health don't feel the need to have the wider accountability that social work seems to feel" (SW008)

Whilst health staff often described a sense of duty to respond to needs, the perception that the responsibility to meet specific needs was outwith their control was often raised. Local Authority responsibility for providing and funding community care services were often described as reasons for referring on. The notion that nursing staff assessed, referred and retreated was contested by many health professionals although some did acknowledge its existence,

"It may well be that the solution to the needs identified is totally outwith your hands but that does not mean to say that you don't follow it through. But then some people simply pass it on and act as though they have washed their hands of it. I see that happening and it worries me" (N017)

The duty to respond as nursing staff was highlighted by most of those interviewed, often through comparison with social work staff. Despite recognising their inability to access directly those resources identified as required, some nurses asserted their professional duty to at the very least monitor a patient's situation until such times as appropriate services were initiated. The implications of staff time, caseload pressures and personnel were described by one CPN,

"When I worked for the care of the elderly team, I can guarantee that 80% of my caseload was on my books because of social work waiting lists; they were waiting for either nursing home placements or day care. And if the purse strings could have been loosened I could have discharged 80% of my caseload" (CPN008)

Actions undertaken in order to address needs were identified as factors outwith the control of many of the interviewees. Whilst professional expertise and assessment skills supported the identification of needs,

organisational factors were considered to influence the extent to which needs could be addressed. This knowledge was frequently expressed by interviewees who in some cases responded by blaming other organisational processes. Despite this, many assessors identified their particular contribution within the context of external factors. One senior social worker reflected on the distinct role of the social worker and that of care planning in the process of assessing and addressing needs,

“The thing I always emphasise with workers is that assessment is only part of the greater care planning and care management. I always emphasise that there is the change agent aspect to the work as well. It’s not just about assessing and providing services. I think that if social work has a particular role it’s hopefully about how we address the changes and help people make decisions. So negotiating, brokering changes with clients, with carers and with other agencies” (SW005)

The role of care planning in relation to assessment and care management was discussed by a few interviewees, however in general reference to care interventions was more often described within the context of needs identification and assessment. Rarely did interviewees separate the assessment of need from the planning of care and then its implementation and subsequent review. The process appeared to be amalgamated in practice under the umbrella of assessment, and in a minority of cases, ‘assessment and care management’. This is not to say that assessors did not describe the ways in which they planned to implement care: they simply did not differentiate between the various stages (care planning included) within the wider process. Referring back to the literature review, the plea to separate care planning from assessment appeared to be tokenistic in practice. The recommended differentiation between the stage of identifying need and that of supplying resources to meet needs, (including the separation of need from eligibility criteria as determined by employing professional organisations) was rarely adhered to. Richards (1994) warned against the inevitable predisposition towards bias and away from ‘objectivity’. She also asserted

that unless the separation between assessment and planning is maintained, the distinction between service-led and needs-led assessment will become meaningless. Worth (1998) also described similar difficulties faced by community care staff who, in light of resource limitations had difficulty divorcing assessment from the availability of services.

Of the study group some interviewees specifically considered the requirement to adopt an incremental approach to resource intervention. This was often out of sensitivity to the client and carer's particular situation and perception toward professional intervention,

"I hope that I would not go in crusading, overloading any situation"  
(N005)

For some the professional desire to intervene was described. Some assessors expressed their need to step back from the situation and reflect on the needs identified and actions proposed. The urge to launch in with every recommended resource was clearly an element that assessors tried consciously to curb. Recognition of the values of an incremental approach to service intervention were highlighted by several interviewees.

The need to gradually establish trust and rapport, identify clients and carer's perceived needs alongside professionally determined needs before intervening was often raised. The potential to offend or cause clients to withdraw compliance with recommended interventions was a conscious concern to many interviewees. The nature of the disease, the ageing process, generation and societal perceptions were raised by interviewees in varying degrees throughout the study as potential barriers to the acceptance of help.

The difficult balance between supporting people in the community and maintaining their dignity, preferences and independence was evident throughout the interviews, with all professional groups. Knowledge of available supports and the potential to enhance someone's safety and quality of life, placed many assessors in the difficult position of ensuring

needs were met as effectively and efficiently as possible, without demeaning the individual's capacity to cope.

The role of resource intervention in addressing needs identified, sparked a great deal of debate within interviews about the process of identifying needs and determining interventions. The factors described as influential within that process were then discussed in more detail: these include the factors that support or influence the assessment of need and; the factors which influence the extent to which needs can be addressed. These will be explored in the 7, 8 and 9. Interesting to note that at no stage during the interview questions following both vignettes did assessors fail or refrain from considering service interventions. The perceived need to respond was a compelling component of almost every interview undertaken.

The role of resource awareness and availability clearly influenced the assessment process including how needs were addressed. The notion of assessing and not intervening appeared absurd to many interviewees, unless there were issues regarding client and carer compliance. For many the purpose of assessment appeared to determine the need for interventions: those interventions involving mainly service provision,

“there's no point doing an assessment if you haven't got any of the provisions to follow that through. You have got to be aware of what provisions there are, before you even start offering things to people”  
(N014)

## **6.14 Chapter Conclusions**

The intentions of presenting interviewees with sequenced vignettes within a semi-structured interview were to initiate consideration of the practical application of the assessment process, engage respondents in the study methodology, identify the factors influencing the assessment of need between professional groups and, consider the defining characteristics of needs and assessment. The extent to which needs-led assessment was or could be undertaken could then be explored through discussion with the

interviewee and analysis of responses given during the interview including comparisons with the Comprehensive List and responses provided by the GSG.

Little difference was noted between professional groups in relation to categories of need and associated issues, investigations, interventions. The most striking factor about the presentation of vignettes was the common response given to the initial question, 'what needs do you think exist?' This generally included a description of the need as well as investigative processes, potential interventions, service options and client and carer compliance. It was clear to the author that the assessment included additional components of what is traditionally referred to in social care as 'assessment and care management' or in health care, 'the nursing process'. No distinct stages were identifiable within the assessment process. Areas of need were highlighted, often in relation to the interventions required in order to alleviate them. In some cases interviewees focussed on the process of assessment ensuring the full engagement of the client and carer and associated professionals.

The use of vignettes as a study methodology was supported through its application: interviewees appeared to engage with the hypothetical couple, their needs and circumstances. Interviewees seemed able and comfortable to consider the vignette in current, real life circumstances and applied the assessment rules, norms, constraints and opportunities that would have been applied to actual clients. The degree to which text book responses were offered appeared minimal although the increased uptake of resources, when presented with an extensive and comprehensive list, did suggest that service availability was influential in the process of both identifying and addressing needs.

This chapter has focussed on the needs and interventions identified. The complexity of factors leading to the identification of need will be considered in Chapters 7, 8 and 9.

## **CHAPTER SEVEN**

### **7 ANALYSIS OF THE DEFINITION AND IDENTIFICATION OF NEED**

#### **7.1 Chapter Introduction**

The purpose of this chapter is to consider the definitions of need volunteered during the study and how needs are identified in practice. Main categories of need were outlined from interviews and the top main categories for each theme will be considered in detail, with reference to relevant literature. Less frequently cited definitions will be highlighted but discussed in less detail. Furthermore methods of identifying need will be explored as they were volunteered by interviewees.

From study responses and conclusions drawn from literature, concepts of need affect the approach undertaken to assessment and subsequently needs-led assessment. The ways in which professionals define need, not only reflects the internal dialogue concluding in assessed needs but also exposes the factors that motivate the assessment process and therefore determine outcomes.

#### **7.2 Overview of Definitions of Need**

Whilst interviews provided some insight into the ways in which assessors defined need, each interviewee was asked (during the latter stages of the interview) to describe their own definition of need. This exercise proved difficult for most interviewees who suggested that because daily practice was managed using the common currency of need, the concept was rarely or never defined. Like previously cited authors, need proved to be a highly ambiguous yet pervasive component of assessment and community care. Need was the common currency or language used when describing assessments and requirements of clients yet lacked clear, concise or



consistent understanding (Smith 1980, Twigg and Atkin 1994). For such reasons most interviewees expressed need as a perceptual element unique to the assessor, the client and/or the carer. Other interviewees returned to a theory base and quoted authors on this subject such as Maslow. Figure 17 outlines the frequency of responses provided for the main areas of definition of need volunteered by interviewees.

Definition of Need	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Perception	22	19	2	2	0
Requirement	15	15	2	5	1
Deficit or gap	15	9	2	5	2
Cope with Daily Life	14	14	2	3	0
Independence	6	11	0	2	0
Quality of Life	6	10	1	0	1
Service Requirement	7	9	0	2	0
Maslow	5	3	0	0	0
Desire	3	3	0	0	0

**Figure 17 Definitions of Need Identified by Interviewees**

There was general consensus amongst professional groups about the components which constituted need and the factors that influenced its assessment. At its very basic, need was described by most interviewees as a departure from the norm,

“It’s a condition that someone experiences which is outwith their norm”. (SW024)

The perception of ‘norm’ appeared as elusive during the study as it did within the literature review. This arose within the study where participants used the term freely but without quantification or qualification. The subjective nature of norm was recognised; however there was a general

understanding that 'norm' was a commonly understood component. Smith (1980) explains the issues which inevitably arise:

"On the general level, two separate tasks seem to be confused. On the one hand there is the task of deciding what is meant by 'need'. On the other hand, if what is meant by need is the achievement by an individual or group of a rather extreme score on some measurement standard, there is then the task of determining the 'cut off' point on this standard below or above which 'need shall be deemed to have arisen" (Smith 1980 p55)

Need as a hierarchical concept pervaded many definitions, though few interviewees sought to clarify the concept or professional perceptions thereof. The extent to which interviewees considered need as a personally or a professionally perceived entity appeared to vary between and within professional groups. There was consensus amongst interviewees about the areas which 'need' covered however there were also several instances where different professional definitions of need were considered in relation to role,

"We (nursing) are looking at illness: we are looking after the ill. Maybe social work deal more with the healthy" (N014)

The degree to which interviewees reflected upon the nature of need in relation to how and by whom it was perceived led to questions about concepts and constructs of need. These ranged from the essential to the desirable,

"When we are doing a needs-led assessment are we talking about fundamental needs that are basically down to the brass tacks: 'have you got enough food and water?', or are we talking about what people perceive: it might look like a want to me but it is a need to them. So how do you assess that and balance it up?" (N010)

### **7.2.1 Need as a Perception**

Respondents referred to the definition of need mainly in terms of perception: this was common across professional groups. Perception related to professional and personal perspectives of need: the requirement to combine all information gathered and distinguish needs from wants or wishes was an area also highlighted in relation to perceptions.

Need was often referred to in terms of whose perception of need was paramount. Professionally or personally defined need was described by all professional groups as were the circumstances within which needs existed and were prioritised. Perceptions of need were described from a variety of professional angles, timescales and circumstances and as such highlighted the difficulty in attaching a definition to an entity which pervaded everyday practice and language as the following quote demonstrates,

“I think it is a word that has many connotations: used by the politician it would probably be in terms of resource allocation. In terms of need and allocation you have to have a balance sheet. Seen in the context of a doctor it might be medical needs. Seen in the context of a nurse it might be just nursing needs. Needs might be felt, perceived, it could be anything” (N015)

The ambiguity surrounding the definition of need and how it is conceptualised in professional practice has been highlighted by many authors including Culyer 1976, Timms 1977, Lightfoot 1995 and Nolan and Caldock 1996. Perceptual approaches to need typically highlighted several considerations. These included professional and client perspectives, public rights and organisational responsibilities, wants and wishes, professional differences, personal versus professional values and, the value base of care. In some cases the tendency of professionals to ‘group’ needs according to disease or client / care categories was identified: this was apparent across all professional groups interviewed. This approach often justified the assessment type undertaken and the

allocation of resources. Nolan (1994) describes the process of allocation of resources alongside service eligibility as involving the deconstruction of care in terms of specific needs. As such the provision of care is normally custom-designed and delivered to, and within, corporate user groups, in respect to their particular disabilities. Nolan (1994) warns against the assumption of homogeneity of older people and dementia sufferers as client groups. This has driven the search for terms that accurately describe those individuals in question whilst avoiding accusations regarding political correctness and client group consistency. Norman (1984) warns against the issues underlying the semantics:

“words create stereotypes of behaviour and identity, which have a powerful effect on those who use them and on those who are labelled by them” (Norman 1984 p29)

Needs were frequently alluded to with reference to professional perceptions. Particular differences were noted between health and social work staff with respect to ability to verbalise definitions and angles from which needs were perceived. Nurses more so than social workers struggled to verbalise a definition of need. Following a degree of consideration most nurse interviewees offered lengthy definitions of need which covered many of the components categorised in Figure 17. Social work staff were often quicker and briefer in their definitions of need although the requirement to identify whose perception of need was paramount as described by many interviewees.

The ability to identify and quantify needs was an aspect raised by health staff more so than social work staff. The use of assessment models and tools within health care allowed the quantification of need in some circumstances or at least the measurement of degree of impairment from which needs evolved. Social work appeared to adopt a more socially constructed measurement of need whereby norms were identified by what was acceptable to the client, carer and society in general,

“It would be society's view of what is normal: it wouldn't be my wishes imposed upon them. It would be for them to live a comfortable life” (SW014)

Health and social work services operate within a market place philosophy of care with an emphasis on consumerism. Implementation of policy principles into practice is facilitated by a multitude of guidance reports, each assuming shared perceptions of need and the assessment thereof. Two examples are scrutinised by Lightfoot (1995): Assessing Health Care Needs (NHSME 1991) and Implementing Community Care Population Needs Assessment: Good Practice Guidance (DoH 1993a). Both documents define need as the 'capacity to benefit' from care: a factor focussing on outcomes. Lightfoot (1995) highlights the dilemma faced by practitioners whose work is not readily applicable to measurement criteria, revealing,

“some important similarities and differences between health and social care in the construction of policies about needs assessment and setting of priorities” (Lightfoot 1995 p108)

Her findings outlined the key role that 'need' played in the implementation of policy and outcomes for clients and practitioners. The interpretation of need was rarely challenged or standardised within guidance creating stronger dependencies on professional, perceptual approaches. The main findings from the report concluded the following:

Classification of need: whilst guidance assumes some degree of homogeneity within the population, health care need is largely defined within a medical model based on disease classification. Social care need is more often constructed in terms of client group.

Needs and existing service provision: social care guidance advocates a neutral assessment of need, independent of resource availability. Conversely the health model assesses need in terms of capacity to benefit

from existing services, with further emphasis on establishing greater efficiency of medical interventions.

Orientation of view: using a medical model of care, health needs are constructed with emphasis on expert opinion. In contrast social care guidance shifts responsibility to user and carer participation in identification of need. The necessity of reconciliation of both views is alluded to but not addressed within guidance.

Information level and type: health care is constructed by the setting of national standards and identification of national norms, for each medical condition. This approach is quantitative in nature and informed by epidemiological results. Whilst social care guidance accepts the importance of this top down approach, emphasis is placed on a mixed perspective, combining this with a bottom up approach which addresses the combined value of qualitative data identified from carers and users views.

Since both health and social care share similar responsibilities with respect to needs-led assessment, fulfilment of the role of assessor will depend on how needs are defined and identified.

During the study, the opportunity and temptation to impose professional perceptions of need upon clients, carers and their circumstances appeared to be actively resisted by most interviewees. The requirement to establish need from the perspective of the person/s being assessed and then interpreted by the interviewee in light of their professional experience, knowledge and expertise was highlighted by assessors from all professional groups. The degree to which the latter directed the former was often dependent on the assessor's professional motivation which included aspects such as resource awareness, equity of service provision, risk aversion, client determination. For practitioners a dichotomy emerges: as front line workers nurturing a relationship of trust and confidentiality with patients and carers, there is a tendency towards decision making which involves a degree of value judgement. Studies on

decision making have suggested that policy making within the NHS tends to revolve around finance, clinical interests and commitments to existing projects which is contrasted against the individual needs of clients (Haywood and Alaszewski 1980). For practitioners the dilemma between an economic, epidemiological approach to meeting needs versus a more social justice based approach becomes a moral one. Lightfoot (1995) suggests that in light of the distinctive nature of caring professions and public service, in practice they may favour smaller gains for many people against greater gains for few.

Given the different training, culture and agendas, which exist between professions, difficulties arise in practice regarding the ability to operationalise the concept of need (Richards 1994). Smith (1980) argues that it is impossible to maintain a distinction between need as a property of service users or need as defined by a statutory agency. The ways in which need is defined by a particular care agency or authority is value laden and tempered by the beliefs and standards of that particular agency (DoH 1991b). Smith (1980) explains that the procedures by which need is defined are difficult to disentangle from,

“the precepts, concepts and theoretical models of social workers and others who are professionally employed in the business of meeting need” (Smith 1980 p66)

Caldock (1993) argues that social workers and community care practitioners feel that medical opinions about care needs have prevailed even when social care was the priority. Indeed during the study, increased risk often changed the priority given to personal versus professional perceptions of need. Where risks or additional needs were considered excessive then professionals would override the needs identified by clients and act upon professionally determined definitions of need.

“I'm the worker at the end of the day so it would be my perception of what the needs are” (SW017)

Caldock (1993) described professional anxieties about 'sticking their necks out' to support the wishes of clients in case an unfavourable outcome such as a fall or injury led to recrimination and a weakening of their position in future cases. Similarly Caldock and Nolan (1994) identified that social services staff felt strongly that health services staff had a poor understanding of the principles of multidisciplinary assessment and showed little commitment to it. These criticisms were most often directed at medical staff in hospitals and general practice. Caldock (1996) suggests that different concepts of health, welfare and organisational structures militate against effective assessment and care planning. Here it is suggested that this affects the protection of older people's civil liberties and right to decide upon what risk they consider acceptable rather than professionally tolerable risk. Similarly Hunter (1988) describes the,

"Multiple and sometimes conflicting objectives of agencies, services and professionals who do not share a unitary perspective on service issues or the needs of clients" (Hunter 1988 p171)

The consequences of negotiating definitions of need and responding effectively and appropriately place the assessor in a precarious position. The study identified that practitioners' perceptions of need were often described as involving a balance between wishes/wants and actual needs. In relation to wishes and wants, client based perceptions of need were described as coloured by elements of want as opposed to need. The importance of client determined need, tempered with professionally defined need was identified by most as constructing the concluding, defining need.

"It's a combination of subjective and objective need. You would consider needs, feelings of need, when does a need become a demand and how effective is a demand? It's a combination of what I as a professional thought the needs were, compared with self-perceived need" (N028)



This echoes sentiments from Curnock and Hardiker (1979) who consider formulating an assessment as a weighing process, balancing risk, need and resources. While this is described as an attractive definition, Worth et al. (1995) suggest that with the rise in consumerism, an important addition to the equation is that of self-determination on the part of the client. Ellis (1993) describes the challenge for frontline practitioners to accommodate individual perceptions of need within a framework of organisationally defined needs. In relation to older people who suffer multiple pathologies in conjunction with advanced age, assessment of need should consider a variety of aspects.

### **7.2.2 Need as a Requirement**

During the study needs were described as both requirement and a deficit. The emphasis placed on either of these components often reflected the interviewee's perception of need as a 'need for' i.e. a positive requirement or a 'need with' which was often defined as a deficit. Although these two definitions appear similar, they were separated during analysis because need as a requirement was often proceeded with a resource intervention whereas need as a deficit was more likely to be presented as a statement of fact. Where needs were references were frequently made to a 'need for': The 'for' in some instances related to resource interventions; in others it related to assistance or enhancement in order to attain or retain skills, quality of life and functioning. This differed from need perceived as a deficit: in such cases needs were defined as 'needs with' which in general related to aspects of daily living. Comments in relation to the latter rarely focussed on the resources or interventions required to address needs but were presented as simple statements of fact with little or no indication of the intervention required in order to address the need in question. In some instances needs were described as both requirements and deficits therefore it was difficult to distinguish whether needs were considered positive requirements or negative deficits. In either case need was considered as a state of being which originated as a result of particular cause/s which required action in order to manage or eliminate the state of need. A definition based upon need as a

requirement was a common professional perspective presented by health, social work and housing professionals. It was supported with suggestions about what, how and why certain requirements existed. Definitions extended from the general to the specific,

“A need is a something that somebody requires to improve the quality of their life, medically socially, emotionally, physically or spiritually” (GP001)

There has been much criticism of traditional systems of care being defined in terms of service availability as opposed to individual need. However a failure to adequately define what ‘needs-led’ means, suggests Nolan and Caldock (1996), is exacerbated by the fact that ‘practitioners seem to have no vocabulary for defining need without reference to ‘service terminology’ (DoH 1993), (Nolan and Caldock 1996 p79). In a similar vein Culyer (1976) highlighted the distinction required between the need for health services and the need for health: an issue which incorporates a pragmatic view of care provision for those in need. Lightfoot (1995) states that economists argue that if the focus is on understanding the end state needed (the outcome), the choice of means or instruments (that is, services) would then become,

“A technical matter which, while in practice is not devoid of the necessity for making judgements, does not require the making of value judgements, about the ultimate needs of individuals” (Culyer 1976 p14)

The dichotomy, which prevails, involves a definition of need in terms of desired outcome or eligibility criteria. Futter and Penhale (1996) describe that whilst research demonstrates commitment to the principle of viewing needs on an individual basis, it appears some practitioners limit the extent to which need is recognised within assessments due to the pressures they perceive exist within tightly managed budgets.

Need as a requirement was expressed during the study as an element of necessity without which individuals could not function at their optimum. The cause of needs was discussed in relation to its definition as a 'requirement'. For need to be a requirement, many interviewees identified a point of reference against which needs were considered to exist. Professionals' consideration of the client's norm was often this point of reference: any detraction from the norm could be perceived as a need or a requirement in order to return that person as close to their norm as possible,

"A need might happen if a person for some reason can't do the things that they were once able to. It's something that is required to get them back to normal or as near to normal as can be possible"  
(SW015)

The notion of norm was raised by many interviewees. Respondents were asked to define norm and in some cases professionals considered norm as their professional perspective on what should be normal for an individual of a given age with a certain set of health and social circumstances: in other cases norm was determined by the client/s. In the majority of cases, interviewees recognised the subjective nature of 'norms' and many considered a client's norm to be an amalgamation of personal and professional perspectives. The degree to which a client was considered to have strayed from their norm, appeared to influence the extent to which interviewees would address needs.

Smith (1994) argues that for assessments to be truly needs-led, there must be a separation between the assessing practitioners and systems of budgetary control. Futter and Penhale (1996) argue that if practitioners are also accountable for budgets they can do nothing but continue to act as gatekeepers, rationing scarce resources. Needs-led assessment which incorporates greater user voice and choice is heralded as the way forward but as Myers and MacDonald (1996) describe, this does not occur effortlessly. In practice terms it is envisaged that the transfer of power will be achieved through involving users and carers in actively defining

their needs through the sharing of assessment recording tools, access to care plans and the facilitation the choice of options wherever possible. In addition, enabling service users to become empowered consumers discourages dependence, facilitates greater client/carer commitment in realising objectives and, provides resource recipients with a sense of control (Myers and MacDonald 1996).

Control, whether professional or personal was interlinked with the perceived level of risk associated with needs. During the study, if needs were considered manageable or low risk then often these were not recorded by professionals as needs of necessity but more desires. Where clients were perceived to have strayed significantly from their norm then the urgency and priority with which need was considered often led to quicker mobilisation of resources to support the client toward their norm. The description of need as a requirement appeared to suggest a professional responsibility to respond as opposed to optional interventions. Where need was perceived as a requirement, the approach to needs-led assessment often meant resource driven assessments or at the very least, resource described assessments.

The needs-led approach to assessment is often described as being at odds with several principles underpinning community care guidance. 'Caring for People' (DoH 1989) emphasises user choice which is defined as giving people a greater say in how they live their lives and the services they need to help them. The promotion of choice and increased independence for individuals by provision of care by non-statutory providers is seen as a critical element in policy. Futter and Penhale (1996) describe the shift within local authority social services departments to an enabling role, facilitating the use of private forms of care. This, it was anticipated, would result in benefits for the individual consumer as services would be provided more cost effectively and would meet the needs of individuals more flexibly. However critics of this approach have argued that choice is restricted by financial constraints imposed on local authorities by government (Futter and Penhale 1996).

Needs-led assessment therefore appeared to offer opportunities to some and constraints to others. The perception of need as a requirement or a deficit was dictated by the professional's motivation during the assessment process and directed the outcome. Similarly need perceived as a deficit was motivated by conceptual factors which affected the identification and recording of need and subsequent need-meeting activity.

### **7.2.3 Need as a Deficit or Gap**

Slightly more health than social work staff defined need as a deficit or gap in a person's life. In some cases interviewees would progress the concept and describe the interventions or requirements needed in order to address the gap. Several interviewees described need as a component which was lacking in someone's life. Dependent on the perspective adopted, that component could be essential to safe living or might be an element related to quality of life. From both a professional and a personal perspective the deficit might lead to a need considered as necessary or desirable. Most of these interviewees identified that, despite the varying perspectives, needs which were considered essential and not desirable were more likely to be addressed by organisations.

As part of the shift from a service-led to a needs-based culture, local authorities are to frame policy statements in terms of the needs for which they accept responsibility rather than services available (Ellis 1993). If all needs were capable of being met, Lightfoot (1995) argues, that rigour in defining need would not be so critical. Set within the context of finite resources most considerations of need are preoccupied with issues of resource allocation and priority setting (Davies 1977). Lightfoot (1995) suggests that one way to deal with the dilemma of resource allocation is to draw a tight boundary around what is understood by 'need'. Applied to a hierarchical approach to need satisfaction, this would attempt to ring-fence resources for a set of basic needs. It then follows that decisions about priorities are appropriate only to residual needs beyond the basic

level (Lightfoot 1995). However Twigg and Atkin (1994) contend that a needs-led assessment assumes that needs have:

“a clear and stable existence; that their legitimacy is unchallenged, and that definitions are shared by agencies and citizens” (Twigg and Atkin 1994)

Despite the theory and the policy, a definition of need that is not incongruous appears to have been evaded. The key to success, suggests Twigg and Atkin (1994) lies in the greater specificity of aims. If a market place economy of health and social care is to become the successful enterprise anticipated, then purchasers and providers need to share the same currency. If that is to be a needs-led prerequisite for assessment and care then there requires to be common definitions with a shared understanding.

“Because care management begins with needs rather than services, it is essential that all care agencies and practitioners share a common understanding of the term 'need'” (SSI 1991b, para 10)

Worth (1998) however describes notable variations in perceptions of the purpose of needs assessment. For the policy makers, the purpose is,

“to understand an individual’s needs; to relate them to agency policies and priorities, and to agree the objectives for any intervention” (SSI 1991b p47)

Section 47 of the NHS and Community Care Act (1990) states that it is the responsibility of the local authority, ‘to assess the care needs of any person who appears to them to be in need of community care’. There is therefore the assumption that at the end of the assessment, community care services will be offered if not provided. Caldock (1993) identified differences in the ways in which practitioners viewed the process and outcome of assessments. Some individuals felt pressurised to offer services at the end of the assessment, others felt that the assessment

process was of itself therapeutic even if the conclusion was reached that no service was required.

A study by Allen et al. (1992) indicated that in the case of care provision for older people, practitioners were reluctant to raise expectations that could not be fulfilled whilst their assessments of need were constrained by what they knew to be available. Similarly Worth et al (1995) describes reluctance on the part of practitioners and managers to record and collate evidence of unmet need in a systematic way. This occurs despite the specification in policy guidance that unmet need should relate both to needs which are eligible but unmet because of resource constraints, and new meetable needs identified but not yet addressed (DoH and SSI 1991a).

Richards (1994) explains that the concept of unmet need also rests on the problematic assumption that practitioners operationalise their definition of need independently of agency rules. Identification of unmet needs for which no effective resource exists is a concern for practitioners who are unclear about legal responsibilities and implications: the fear of being open to legal challenge by users/carers is tangible (Williams 1999, Shearer 2002, Raven 1999, Stalker 2003, Caldock 1995, Bonuck 1996, Williams and Bowie 1993).

Lightfoot (1995) describes the lack of structures means whereby practitioners can feedback intelligence from the assessment process for planning purposes. This is further inhibited by concerns over the inability to satisfy legal requirements to meet unmet need. Ellis (1993) describes 'damaging behaviour' within front line workers which is attributed to their sense of despair in trying to meet service ideals within a regime of tightly managed resources.

Caldock (1994a) describes organisational disincentives for overspending, which outweigh the incentives for professionals to acknowledge users' and carers' needs, which cannot be met. Similarly Worth et al. (1995) describe the caring ethic within which district nurses operate which leads

to a broad range of interventions. Traynor (1994) notes that community nurses draw their sense of purpose from an emotionally powerful experience of caring and relates this to stress experienced at an inability to meet needs. Nolan and Caldock (1996) conclude that in the face of these pressures, practitioners are placed in a no win situation discouraging them from case seeking and straying beyond obvious needs. Baldwin and Woods (1994) describe this as a major barrier to achieving good assessment practice. Ellis (1993) argues that assessors are rationers of care and services and that this provides them with little incentive to probe too deeply. Caldock (1994a) suggests that practitioners see a lack of resources as a significant hurdle and that identifying needs which subsequently cannot be met is likely to result in disillusionment and low morale amongst staff. This, suggests Nolan and Caldock (1996),

“places practitioners in a paradoxical situation as they are being encouraged to expand their own horizons and think creatively and holistically, which may raise expectations in users and carers, whilst simultaneously being required to ration demand” (Nolan and Caldock 1996 p82)

When describing need as a deficit or a gap many professionals considered it from the perspective of the client. Deficits appeared to be identified by clients and carers during the course of assessments and were expressed as needs following professional interpretation,

“A need is a deficiency in skills that people would normally expect to be able to achieve. It’s based on what they perceive they should be able to do and what they are limited in what they can do. It’s not a desire” (Nolan 1994)

Need as a disabling component reflected concepts outlined within the literature review. Theorists whose perspectives incorporate views about social oppression for example argue that such an approach equates need with deficiency and tends to pathologise the individual (Futter and



Penhale 1996). The perception that need suggests a deficit is reinforced in community care guidance which states that,

“needs are said to show a requirement for individuals to enable them to achieve, maintain, or restore a respectable level of social independence and quality of life, as defined by the particular care agency or authority” (SSI/Social Work Services Group 1991 p14)

The notions of need and resultant care are value laden and interpretation is determined primarily by the context in which care exists. Care, traditionally described, carries moral, social and relational connotations which suggest an interaction between those providing and those receiving care (Henriksen and Rosenqvist 2003, Young 1996). When applied within community care literature, care and caring become a formalised activity culminating in the satisfaction of needs on one hand and the delivery of a service or intervention on the other. This concept constructed in the form of care or case management, suggests Walker (1993), lends itself towards a description of need in terms of dependency. This, he argues, is paradoxical to the facilitation of independence and empowerment that underpin much of community care philosophy and rationale. Caldock (1993) argues the theme of 'Caring for People' focuses largely on paternalism and points out, endorsing Lloyd (1991), 'the strong managerialist tone evident in the great power invested in professionals to allocate available resources destined for those in greatest need'. Illich in 1976 shunned the foreseeable misconceptions of an authoritative approach to assessment which defines needs against intentions, proposing that:

“We name the mid-twentieth century 'The Age of Disabling Professions', an age, when people had 'problems', experts had 'solutions' and scientists measured imponderables such as 'abilities' and 'needs'” (Illich 1976 p11)

Many interviewees appeared to revert back to what clients considered their norm and again this was used as a reference point from which

deficits or requirements were determined, despite the fact that 'norm' was never quantified or standardised. If interviewees encountered clients for the first time it often became a priority to establish their norm and to work from that in order to identify needs, then interventions. Achieving normality or moving towards the attainment of normality for clients was a goal often expressed by professionals, clients and carers. Barriers to this were perceived as needs often using negative and disabling language such as deficits, gaps, lacks. The ability to quickly ascertain deficits and work with clients towards removing barriers was considered a critical component of the assessment.

The ability to quickly and effectively identify gaps was determined by the professionals' ability to build rapport, trust and elicit information to assess needs. For some interviewees, the ability to apply a model of assessment or follow an assessment tool facilitated the process of translating information gathered into assessed needs. Interviewees found it easy to refer to needs as deficits which by definition required interventions. The process by which deficits were determined was dictated by the assessment model adopted. Several interviewees referred to layers of need with basic needs taking precedence over less essential needs: the latter relating mainly to quality of life issues as determined by the interviewer.

"Need is something the person hasn't got and should have. It's considering different layers of needs from basic needs onwards e.g. sanitary needs, hot and cold water, heating etc" (N003)

Professional definitions of need as deficits or gaps focussed around identification of the most basic of needs before moving onto more specific and less essential needs. Maslow's hierarchy of need helped to provide a framework for identification of needs. In addition to this some interviewees deconstructed needs into broad categories such as physical, social, psychological and utilised this model to structure their own personal definition of need. Comprehensive assessment and a more diverse range of non-statutory providers are seen as being ways to help

achieve greater client and carer choice (if not control) (Caldock 1994b). However Ellis (1993) reports that attempts to progress these issues with creative problem solving approaches have only succeeded in describing what could be provided within current organisational and budgetary constraints i.e. needs are responded to in terms of existing service provision. This is of particular relevance as, since 1993 unmet need identified in individual assessments must be recorded and fed into service development and planning (SSI 1991). This differs from past approaches to community service planning which incorporated epidemiological considerations of actual or potential need. There is now a greater emphasis on needs assessment as a basis for planning and contracting services.

The NHS and Community Care Act (1990) also required local authorities to purchase but not necessarily provide in-house, appropriate community care services based upon an assessment of need (Lightfoot 1995). The consequences for community care provision are far reaching. According to Hughes (1995),

“the way in which assessments are conducted, recorded and collated will have a major influence on the extent to which the community care process is either organisationally oriented or user oriented, resource led or needs-led” (Hughes 1995, page145)

However the development of new needs-led assessment recording tools aimed at covering all angles and satisfying all parties involved, has become long and complex (Baldock 1993). This argues Caldock (1993) is an example of the conflict between a user led, participative approach and the managerial methods through which such services are expected to be organised and delivered. One dilemma that emerges is described by Ellis (1993) who states that assessment has usually served the dual function of identifying need and determining eligibility. For such policy to maintain integrity there must be some compromise between individual and corporate need. Less optimistically, Lloyd (1991) argues that:

"A bottom up approach which stresses the right of elderly individuals or consumers of services, to express their needs and have a say in the selection of services offered, to control their delivery and to protest when things go wrong is incompatible with the top down approach with management assessing needs and deciding who is most needy, allocating scarce resources, rationed by limitation on funding, and adopting a professional stance before the dependent recipient of services" (Lloyd 1991 p129)

Carter et al. (1995) describe ways in which different concepts, methodologies and meanings of need produce different information about what is needed. Similarly, in terms of outcome, Carter et al. (1995) speculate that bottom up and top down methodologies differ in that a client centred needs assessment (i.e. bottom up) may result in more localised, flexible and responsive means to establishing and evaluating the expressed needs of people. Stalker (1993) argues that unless assessment information is systematically analysed with a focus on outcomes for users then there is a risk that future needs will continue to be calculated in terms of available provision, political preferences or financial constraints. Therefore the viability of developing an assessment recording tool which encompasses these concepts and compromises the contradictions inherent to the models described comes into question. In the hands of a skilled assessor, it is contested; an effective assessment package can be invaluable tool, although it has been argued that a comprehensive package does not lend itself easily to documentation. Baldock (1993) suggests that new assessment procedures,

"Instead of becoming an aid to discovering user's needs [...] have become a bureaucratic obstacle to the process" (Baldock 1993 p7)

The individualisation of need is not always considered a positive, enabling and constructive approach for clients. Theorists whose perspectives incorporate views about social oppression for example argue that such an approach equates need with deficiency and tends to pathologise the

individual (Futter and Penhale 1996). The perception that need suggests a deficit is reinforced in community care guidance which states that,

“needs are said to show a requirement for individuals to enable them to achieve, maintain, or restore a respectable level of social independence and quality of life, as defined by the particular care agency or authority” (DoH and SSI/Social Work Services Group 1991 p14)

Caldock (1994b) criticises the ‘betrayal’ of such a definition, highlighting the contradictory language of independence, participation, user control alongside that of managerialism and professional control. With already elusive terms, apparent discrepancies in policy add to the ambiguity. Caldock (1994a) also draws attention to the section of policy guidance which states that competency assured, the users' view should carry the most weight (DoH and SSI/Social Work Services Group 1991a p14).

Despite this policy plea, attention is drawn to the conditional component which states that,

“ultimately the assessing practitioner is responsible for defining the users 'needs'” (DoH and SSI/Social Work Services Group 1991a p53)

The focus of health care on the incidence and prevalence of disease in conjunction with costs and cost effectiveness of services and interventions has been criticised and justified in terms of pragmatism. Likewise advances in social care in terms of aggregate data concerning corporate need and innovative demand has been termed idealistic, creating ethical and legal considerations regarding identification of unsatisfiable unmet need (Cairns 1996, Stoddart et al. 2002, Roberts 2001, Nolan 2000, Stalker 1994, Parker 2002, Hawkins et al. 2001). Inter and intra disciplinary inconsistencies have also been identified as causal components of internal and external influences determining the successful application of needs-led assessment (Glasby 2003, Healy and Meagher 2004, Sheppard 1986).

Nolan and Caldock (1996) conclude that despite demands for client and carer empowerment, the definition of need in policy guidance reinforces professional supremacy within the assessment process. Richards (1994) asserts that self-determined needs of clients or carers will only achieve formal recognition if they coincide with existing policies and the priorities of local agencies.

Need, regardless of whether it is defined as a requirement or a deficit or both, highlights the capacity to benefit within a client's life. The meeting of needs fully or partially was considered by many interviewees as important as identifying needs in the first place. Many interviewees argued that the purpose of the assessment was not only to identify need but decide on interventions.

#### **7.2.4 Need as the Ability to Cope with Daily Life**

The ability to cope with everyday life was cited by interviewees across health and social care as a definition of need and incorporated several aspects considered essential to independent living. Some models of assessment were developed around everyday living and interviewees described undertaking assessment of need based upon models and factors integral to everyday life,

"If you look at someone's activities of daily living and you find a need in a particular area: how they function on a day to day basis, what they need in order to do that and if there is a particular function they can't do then I would identify that as a need" (SW030)

The ability to identify needs based upon a definition of 'ability to cope' with everyday life, led interviewees to consider daily tasks and the requirements essential to complete those tasks. In the case of determining a person's ability to cope, and defining need as a description of this, several interviewees considered a granular approach to assessment which began with basic needs then evolved into more quality

of life issues. In some cases resources were described as 'basic' in that they addressed the most basic of needs. Needs considered more desirable than essential were more difficult to meet because of a lack of resource provision, organisational justification and funding. This was reflected in the literature review where the use of Maslow's Hierarchy of Need supported organisational prioritisation and resource allocation (Davies and Challis 1986).

The ability to cope with daily life did not stop with practical issues: for several interviewees, a critical component was the psychological impact created by being in a state of need. Some interviewees considered it more important to explore what motivated individuals in order to understand factors important to them before concluding the impact that ill health or disability exerted upon their life. Ill health was often cited as a cause of inability to cope with daily life. Slade (1994) describes various approaches to mental health needs, which focus on outcomes as well as processes. These are the need for improved health, needs for services, need for actions, and perceived need. While the need for health describes many standardised measures, the need for resources and actions assume that needs are alleviated by particular services or interventions. The Medical Research Council's Needs for Care Assessment defines need as present when the person falls below a specified level due to a potentially remediable cause (Brewin et al. 1987). Study results echoed these findings as not all needs associated with coping with daily life reflected practical requirements: many referred to the coping skills and motivating factors which allowed clients and carers to continue living successfully in the community, (often defined by themselves).

The reality of the progressive nature of disease and old age led several interviewees to consider the psychological and spiritual side of need: both its definition and identification. The ability to cope or manage illness or disability was sometimes the best that interviewees, clients and carers could hope for and this was the shared goal toward which everyone worked. The role of rehabilitation was often cited in relation to the ability to cope with daily life. The need to equip clients and their carers with the

necessary resources, both internal and external, was highlighted as definitions were discussed.

### **7.2.5 Need as Independence**

Need was often described with reference to client independence and the requirement to assist them to achieve or retain independence. References to independence reflected the direct role that professionals exercised in achieving this goal. Some interviewees regarded their contribution as emotional or psychological support, others as a coordinator or manager of care, and others as a direct resource provider. The latter was true of situations where interviewees considered themselves as assessors and service providers: a duality of role that was witnessed more so amongst nursing staff than social work staff,

“You are trying to bring someone back to a status quo that will allow them to function physically, mentally or emotionally in a way that they currently can't provide for themselves. You are trying to provide that for them by assisting them and getting them back to a state where they are able to do it for themselves” (N002)

The need to promote independence whilst providing assistance was described by interviewees as a fine balance which required dissociation from the urge to ‘do for’ and exercise a ‘do with’ attitude. The notion of clients and carers as partners in care was espoused with the client considered central to the defining, identifying and addressing of need.

Need defined as a need for independence suggested a move away from a paternalistic role towards a more enabling role. Independence also suggested the need for action on the client’s part and moved some of the need-meeting responsibility from the professional to the client. The client’s perception of need and their view of independence were critical to the definition of need and subsequent actions. The setting of references by clients, against which deviations from normal levels of independence



were identified, often served as the baseline from which professionals identified need and supports required.

#### **7.2.6 Need as Quality of Life**

Another definition of need centred on quality of life issues. Needs were referred to by some interviewees (mainly within social work) as components of quality of life and therefore the requirements which resulted in needs were reported with reference to quality of life issues. Perceptions of what constituted quality of life varied within and between professional groups, with some interviewees referring to general areas and others referring to specific components, each subject to personal and professional perspectives.

The scope of need defined as quality of life was reflected in several responses which included additional components such as independence and requirements. Some interviewees limited their definitions to the parameters of quality of life: specific examples were offered as key contributors to a client's quality of life, as one social worker described,

"A need would be some distinct item or operation that would enhance the quality of life for the individual in a positive way. That might be a bath seat or a befriender" (SW008)

Need as defined in terms of quality of life, like so many other definitions, involved the notion that some form of intervention was required. Therefore where need was considered in this way, expectations were expressed on behalf of the assessor that actions would be undertaken. The subjective nature of quality of life perceptions was highlighted by several assessors who recognised needs which were invisible to clients. Most professionals identified a general balance between professionally determined quality of life and personally (i.e. client) determined quality of life. Assessors often reverted back to hierarchical concepts of need where basic needs were highlighted initially and given priority and the less essential, more desirable needs were considered. Whilst many assessors

recognised the importance of the desirable elements in terms of self actualisation, the reality of being able to meet these needs in the community appeared low.

#### **7.2.7 Need as a Service Requirement**

Quality of life was reflected in some definitions of need which were centred on the notion of service requirement. Some interviewees described needs as a need for particular interventions, often service related. The concept of need as a requirement preceded statements made by interviewees when defining needs as resource requirements.

“If you have a need then you require something, some kind of service, or adaptation: you need something more than the average person who is managing their life” (H005)

The concept of ‘average’ or ‘normal’ was frequently cited with little reference to what constituted normality or the ‘average person’. In some cases the service requirement was based largely on the client’s wants and wishes. The notion of providing resources to maintain an individual within the community as well as maintaining a level of daily living that was acceptable to both professional and client was highlighted in several of the definitions where service requirement typified need.

Need defined as a ‘service requirement’ suggested an outcome focus to need and needs assessment. The process whereby needs were defined appeared to be based upon the professionals’ area of focus and from the definitions so far considered. These seemed to range from the process of need identification to perceived outcomes. Where models were applied (either consciously or subconsciously) needs were described and defined in relation to their area of focus.

### **7.2.8 Need as Described by Maslow**

Maslow's hierarchy of need was cited explicitly by several interviewees during their definition of need, although others did make reference to a hierarchical structure without referring directly to Maslow. Only those who cited Maslow are included within this category. As a model for defining needs, Maslow provided interviewees with a structure which underpinned their thinking. The concept of a range of needs from basic 'life and limb' to more 'quality of life' needs, provided a framework which added structure to the definition of need.

The structure provided enabled the assessment of need to evolve with the complexity of need. For interviewees, need could be easily categorised with respect to those categories attributed by Maslow. The hierarchy attached to this sometimes supported professional decision-making about which needs were prioritised and addressed.

"Your basic needs are based upon Maslow's hierarchy of needs. These must be met before you can actually continue onto self actualisation" (N031)

The validation provided by a recognised model of need enabled interviewees to justify their actions. Where distinctions were made between types of need, there was often a resemblance of Maslow's hierarchy with the more 'non essential' needs identified nearer the top of the hierarchical triangle taking less of a priority than the more basic needs identified towards the bottom of the hierarchy.

### **7.2.9 Need as a Desire**

The concept of need defined as a desire was deconstructed by some interviewees and consideration was given to the validity of the client's desires or aspirations. The professional's perception did not always reflect the client's perception/desire and the belief that need was defined as something more than an aspiration or a desire was expressed by each

professional group. The distinction between needs and wants appeared to cloud interviewees' definitions of need with only a few professionals considering need as a desire.

"A need is something that a person has little control over: a want is something that a person has control over and responsibility for"  
(N010)

Where the client appeared to exercise control over certain areas of their life, this was rarely perceived as a need. Needs arose out of deficits, requirements, barriers to independence, quality of life. Should a person be considered capable and competent to address those issues independently then interviewees failed to consider these as needs. Clients' desires were important contributing factors to the assessment process although the weight attached to them tended to reflect the level of control the client exerted over that part of their life.

Entitlement also featured as a component of need as a desire. The degree to which desire constituted need was balanced against various factors such as risk, eligibility criteria, ability to function: these components were considered necessary aspects of the assessment process which involved the identification of needs based upon the definitions upheld and practiced by professionals. In some cases needs were clearly distinguished from wants by professionals who accepted responsibility of separating needs from wants.

"It's like talking to kids: it's about 'you don't need that, you just want it'" (N026)

Throughout the interviews, few respondents endorsed the definition of need as a desire. Most interviewees made the distinction between the client's expression of need and the professional's interpretation of need based upon professional experience, knowledge and expertise. The difference between a request and a requirement was cited as an indication of whether a need existed or a desire was being expressed.

Where requests were made by clients or in some cases, professionals, a judgement based upon assessed need appeared to be the main way in which desires were distinguished from what was often referred to as 'actual need'. The client's perception was often described by interviewees during the assessment process and recorded, however the needs identified appeared to be based less on desire and more on the professionally perceived requirement to respond.

### **7.3 The Identification of Need in Practice**

The concept of need as described above clearly influenced the assessment thereof and was reflected in responses to the vignette sequence. When asked 'how do you identify needs?' interviewees provided several response types which provided insight into the decision-making processes which culminated in the assessment of need and ultimately their ability to be needs-led.

The process of identifying needs is recognised within the literature and in practice as a complex area, comprising both conscious and subconscious elements (Crome and Phillipson 2000, Vernon et al. 2000, Howe 2003, Muir 2004, Vellinga et al. 2005). By asking interviewees to describe how they identified needs with respect to the sequenced vignettes and then within a semi-structured questionnaire, elements considered influential to the assessment and decision-making process emerged and are described.

Not all interviewees found needs-led assessment an easy area to discuss. For some the identification of need was an automatic process which was difficult to deconstruct or express in component parts. This was the experience of similar studies or reviews including Clarke 1990, Benbenishity 1992, Bryans and McIntosh 1996, Lemmer 1998, Waterson 1999, Parry – Jones and Soulsby 2001, Junnola, et al. 2002, Healy 2003, Neeraj et al. 2005. Other interviewees appeared to enjoy the opportunity to analyse and reflect on the factors which led to the identification of need and described the experience as cathartic.

Many of the elements volunteered in response to the question 'how do you identify needs?', using the vignettes as a catalyst, were similar to those provided in response to a later question which considered the extent to which respondents could meet needs. The relationship between identifying and addressing needs was evident throughout the study. When asked to consider the question 'how do you identify needs (e.g. do you apply a particular model of assessment of need?)', most interviewees offered multiple responses, identifying many elements essential to arriving at the identification of needs,

"Communication skills, assessment skills, organisational skills, networking skills, knowledge base, and training" (SW041)

The specific elements volunteered during the study reflected a complex process of gathering information in order to generate a conclusion and are categorised in Figure 18 by frequency of presentation.

Factors Affecting Identification of Need	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Communication	38	44	5	9	2
Information Gathering	37	44	3	9	2
Perception	27	39	3	5	1
Assessment Tool	26	35	2	9	2
Experience	32	25	5	3	2
Assessment Model	30	20	0	4	1

**Figure 18 Factors Affecting the Identification of Need**

Whilst the majority of interviewees identified more than one factor when considering how they identified needs, social workers in the main identified issues relating to communication, information sharing, perception moreso than other professional groups. Nursing staff volunteered experience and an assessment model more frequently than

other professional groups whilst social work staff identified the assessment tool more frequently than other groups interviewed.

With respect to assessment models and tools, the majority of nursing staff made reference to one particular model of nursing – Activities of Daily Living, which was developed by Roper, Logan and Tierney (1980). In contrast social work staff mentioned a myriad of models with few being identified by more than two interviewees. The method of recording assessment material using a particular model of assessment differed between professional groups, with social work staff more likely to refer to a particular suite of assessment and care management documentation (Community Care Assessments, CC1, CC2, review forms) more so than any other professional group. Therefore whilst a common assessment model appeared to be shared between nursing staff, a common assessment tool appeared to be shared between social work staff. The perception, understanding and definition of assessment tools and models and their impact on practice was highlighted by a few interviewees, as one dually trained social worker described,

“I personally think that a lot of people don’t use any models: they have become so used to using tools that they have forgotten about the underpinning theory that determines how they use the tool”  
(SW040)

The following sections considers in detail the categories identified as influential to the identification of need.

### **7.3.1 Identification of Need - Communication**

When asked to describe how needs were identified, most interviewees provided information relating to communication skills. One of the issues often alluded to by interviewees about the use of sequenced vignettes was the inability to ‘interrogate’ the information presented. This echoed previous studies (Finch 1987, Gould 1996, Rahman 1996, Wilson and While 1998, Hughes and Huby 2004, Vellinga et al. 2005) The use of

communication as a mechanism to establish this was paramount and interviewees described in great detail the communication approaches they would adopt in a real life situation.

Despite being critical to the identification of need and the success or otherwise of being needs-led in their approach, the ability to engage and communicate effectively with clients also appeared a difficult area for interviewees to describe. The component parts of effective communication were deconstructed by interviewees throughout the course of the study and are listed in Figure 19 by professional group.

Communication Elements Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Interview	33	38	5	3	1
Informal Contact	28	35	1	3	0
Listening	22	23	3	2	0
Relationship Building	19	22	3	4	1
Observation	25	17	1	4	0
Professional Contact	8	34	0	4	0
Home Environment	26	14	2	3	1
Several Visits	16	16	0	6	1
Environment	21	10	2	2	1
Intuition	15	12	1	1	0
Family Relationships	6	16	0	3	0
Non Verbal	11	7	0	0	0
Trust	4	13	0	0	0
Respect & Value Client	4	5	0	0	0
Case Conference	2	1	0	1	0

**Figure 19 Communication: Factors Volunteered which Affect the Identification and Assessment of Need**

The complexity of the communication process in the context of needs assessment was evident in the responses given. Few interviewees were



able to deconstruct communication into the categories identified above but referred to several elements critical to the process. The author has therefore attempted to identify the component parts of the communication process described by interviewees but recognises that none occur in isolation: the connectivity of one aspect to another proved consistent throughout the interviews. Literature reflects the necessarily complex nature of communication with authors such as Carris-Verhallen et al. (1997), Meeks (2001), Ringel (2002) describing the interrelated components which constitute a effective communication.

Similarly several components included in Figure 19 were alluded to without explicit reference e.g. the majority of interviewees described discussing issues with clients in their own homes. This not only allowed consideration of the domestic home environment but also provided an opportunity to consider the wider geographical environment within which clients' resided. Nursing staff moreso than social work staff identified the home and environment as elements important within the communication process.

The opportunity to consider the home environment was not the sole reason home-based assessments were preferred by those interviewed. The importance of home visits was described in detail by some interviewees with respect to building rapport and information gathering but many respondents simply described the discussions, with the assumption that these were being undertaken within someone's home. Only when asked specifically if this was the case, did respondents acknowledge the importance of home-based assessments as opposed to office-based assessments.

"I believe nurses and professionals can go into someone's home and can pick up things that they don't necessarily understand – there is an unconsciousness there that we pick up things that we don't necessarily understand. I don't have the theory and the intellectual stuff round about it to understand what I am picking up but I believe

people within the profession have got this alarm bell that goes off”  
(N010)

The notion of professional intuition was one which was referred to by several interviewees and this seemed to occur uniformly across professional groups. Rew and Barrow (1987) and McCutcheon and Pincombe (2001) describe the importance of professional intuition in nursing and reinforce the requirement to respect its role.

Many communication skills were described and/or demonstrated by interviewees in the course of the study. From the obvious verbal forms of communication to the less obvious non-verbal forms, assessors appeared able to collect and assimilate an enormous amount of information from the course of a discussion. ‘It’s not hard facts’ described one social worker (SW024), ‘it is about hints and clues’. Clearly interviewees had developed specific skills which allowed them to sift through a vast array of information and conclude that certain needs existed and required to be addressed. Interpretation of need from information gathered was a key skill identified by many interviewees.

One of the difficulties identified in relation to professional intuition was the potential to preconceive needs before undertaking a full assessment. Having learned to expect certain needs associated with particular conditions, referral information and age, some interviewees did identify the potential to pre-empt the outcome of assessments. Many interviewees alluded to the tension to deliver an outcome before they had undertaken an assessment.

Unsurprisingly, the most frequently cited method of communication was that of interview. Interviews with clients, carers, professionals and other associates were highlighted as the preferred method of communication: this was accepted as a given by the majority of those interviewed across professional groups. The format of these interviews was often discussed by professionals with many adopting a conversational approach to

initiating discussions, establishing relationships, defining needs then recommending interventions.

The process of information gathering, for many assessors, was dependent on the quality of the relationship experienced with clients and where appropriate, their carer/s. The requirement to invest time and energy in developing and establishing therapeutic relationships was often highlighted across professional groups. The concept of gaining trust was explicitly expressed more frequently by social work staff than nursing staff. This is not to say that it was considered less important by nursing staff: social work staff in the main appeared more consciously aware of the need to base the client/professional relationship upon trust. One aspect of this was the process of listening which was overtly expressed amongst professional groups. Listening was often described in terms of both verbal and non-verbal cues. An awareness of body language, reactions, and interactions enhanced the communication process and was utilised by many.

The ability to listen and reflect on the information provided by a variety of sources was perceived by interviewees to contribute greatly to the whole process of communication. Listening was rarely mentioned without consideration of observational skills: the two appeared to operate in tandem. The emphasis placed upon listening to and being directed by clients and their carers was raised by many of the assessors interviewed. Listening did not just serve the purpose of aiding reliable information gathering, but was considered a critical component of the professional/client relationship.

The process of listening to and being directed by the client seemed to establish some ground rules upon which trust and rapport could be built: for most this seemed an automatic, intuitive process. The experience gained through practice and professional development within the field of active listening and reflecting led some interviewees to describe in significant detail the approach they would undertake and the purpose for which they would use their listening skills.

“I am building up a picture within myself to get a sense of what it is like for this patient to live in their life. That is my picture but then what I have to do is clarify through active listening and feedback. So from there I can say what would be appropriate, with the resources that I have got to hand, in order to support this person in their life, and make their life better” (N010)

The development of a picture over time was used by several assessors to identify the process of information gathering and needs identification. The picture created often began at the point of referral as defined by some of those interviewed. An understanding of the type of reception a professional is likely to receive meant that for some, a particular approach was adopted prior to visiting someone at home.

Establishing rapport and building good relationships were identified as factors which contributed to the communication process and in so doing helped to identify needs. The time, skills and expertise required to do this were often described very naturally and apparently effortlessly by professionals who have been engaged in this type of behaviour for several years. In the main the need to regard the situation from the perception of the client and the carer was alluded to more so by social work than health staff and appeared to emanate from social models of assessment. For one social work assessor the mechanism of ensuring clients were respected, valued and treated in a non-judgemental manner was maintained by a particular approach,

“It’s the experience I have had over the years: I will go into a client and I would look at them as if ‘that is my parents’ and I treat the clients as I would like any other social worker to treat my parents I do my best. I feel in my job, if I go out and give them what I would want my parents to get, I can close that at the end of the day and say to myself ‘well I have done a good job for that client and I have made them happy’” (SW022)

The links between job satisfaction and client satisfaction were highlighted in response to the question, 'to what extent are you able to address needs?' and these will be considered in Chapter 9. Suffice to say that being employed in a caring profession appeared to bring with it personal and professional demands that some interviewees found difficult to reconcile.

"I don't think you can divide the social worker from the person. I think what you can do is be aware of any discriminatory thoughts you may have or preconceived ideas. You just need to be aware of how these might impact on the way you would assess peoples' needs or when you are planning services for people" (SW029)

The value added to the professional/client relationship by communicating a realistic and reliable ability to not only identify but to address needs was an area commonly referred to. The notion that assessment led to a conclusion which involved some type of resource intervention or investigation was consistently expressed, sometimes explicitly, other times implicitly. Engaging the trust, establishing rapport and ensuring professional credibility was often linked to realistic outcome focussed assessments,

One defining area was the extent to which communication extended beyond the client and involved informal carer/s and others involved in the care of the individual being assessed. This was reflected during discussion about communication but also within the realms of information gathering. More significantly, was the extent to which social work staff expressed communication with extended members of a client's social network as a routine aspect of an assessment. This was especially noticeable regarding contact with professionals (those currently and potentially involved) and informal contacts. While there was common agreement between professional groups that incorporation of informal contacts within the communication process was a significant component, there was a marked difference in opinion when it came to extending communications to professional contacts. Social work staff were more likely to identify the

routine of contacting professionals regarding individual clients whereas nursing staff rarely raised this in the course of discussions. Social work assessments frequently identified the need to contact all involved in the network of care and also those in contact with the client who could support the creation of a picture which facilitated the depiction of the person, their circumstances and needs.

### 7.3.2 Identification of Need - Information Gathering

The links between communication and information gathering as components of identification of need were such that it was often difficult to separate the process from the purpose. In many instances the process of achieving this was through some of the elements of communication described above, for others it involved the application of tools or models of assessment. The role of information gathering, in its various formats was therefore considered and categorised as outlined in Figure 20.

Information Gathering Elements Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Home Visit	32	30	2	3	1
Informal Contact	22	35	1	6	2
Professional Contact	20	34	2	7	2
Personal Investigation	31	17	4	8	4
Referral Information	21	19	0	6	0
Personal History	19	14	1	5	1
Specialist Assessments	5	3	0	4	1
Using Senses	9	4	0	0	0

**Figure 20 Information Gathering: Factors Identified which Affect the Identification and Assessment of Need**

Similarities with Figure 19 are self evident and support the need to be thorough in the communication process in order to gather reliable information.

Time allocated to nursing staff was perceived to be a contributory factor to health staff's perceived inability to be as inclusive, multidisciplinary and holistic in their assessment of need as social work. In the opinion of one social worker,

"It's the old thing of the medical model versus the social model. A lot of people are saying that they don't have the time and I suppose if they have a clinical role and need to do hands on nursing, they won't have time to find out the broader picture" (SW030)

The 'hands on', clinical aspect of the medical model was described by social work staff as one way in which health professionals typically attempted to 'solve' needs compared to the longer term care management of irresolvable needs.

The requirement to gather information was common across professional groups but the breadth of information gathering did seem to differ between health and social work staff. Another notable difference was the extent to which professionals undertook investigations personally. Nursing staff were more likely to identify the need or describe the action they would undertake in order to investigate matters further: this included performing specialist assessments e.g. cognitive screening, investigating and managing urinary incontinence, asking clients to demonstrate activities or inspect aspects of their domestic life. The sensitivity associated with questioning the reliability of responses provided by clients was often alluded to. The need to establish a realistic assessment of need was used as reason to justify the potential infringement of trust and rapport.

In some cases interviewees described the use of their senses e.g. sight and smell to determine the types of needs likely to exist. This was mainly

referred to with respect to urinary incontinence where there may be some reluctance on the part of the client to acknowledge a need. Similarly the requirement to ensure that all the appropriate information was gathered, using the appropriate means, before concluding the needs status of individuals was often referred to by social work staff.

Whilst social workers were more likely to extend the assessment process to include formal and informal contacts to create a reliable picture of an individual and their needs, nursing staff were more likely to undertake further investigations personally. The focus on relationships by social work appeared to lead to a perceived reliable identification of need whereas nursing staff, through targeted professional investigation appeared to add gravitas to their assessment of need.

From the study information it appeared that social workers identified need based upon consideration of multiple contributors whereas nursing staff based the assessment of need more so upon a detailed professional investigation of the individual's ability to function. This is not to say that nurses did not consider or question informal and professional contacts: references to these components by health staff were more in recognition of their existence and contribution as opposed to the need to actively seek their opinion in reaching an assessment conclusion. It should also be noted that all professional groups identified the need for specialist assessments. The notion that not every professional could carry out all assessment components required in order to gather the appropriate information to assess needs was also recognised.

### **7.3.3 Identification of Need - Perception**

When describing ways in which needs were identified, many interviewees referred to various perceptions and the extent to which each contributed to the assessment process. References were made to the public perception of health and social care and the effects this had on client and carer compliance when assessing and addressing needs. Figure 21



outlines the most frequently identified elements in relation to perception within the assessment process.

Perception Elements Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Client's views & wishes	25	39	3	6	1
Carer's views and wishes	15	35	2	7	1
Professional view	18	23	1	4	0
Personal standards	3	4	1	1	0

**Figure 21 Perception: Factors Volunteered which Affect the Identification and Assessment of Need**

Most frequently cited was the perception of the client, in particular their views and wishes. This view was not held uniformly between health and social care staff. Social workers were more likely to identify client's views and wishes when identifying needs than nursing staff. The practice of establishing needs from the perspective of the person being assessed was described by social workers as integral to their assessment approach. When comparing social work and nursing approaches to client perspectives of needs assessment, one social worker commented,

"We have to and we would want to take more account of the individual's wishes and allow them the responsibility, rather than just saying 'this person requires residential care'" (SW014)

Regardless of different approaches, professionally driven and personally perceived assessments begin with the information gathering and conclude in suitably appropriate outcomes. The perceived benefits in the context of a caring, enabling profession were left for debate. Kempshall 1986, Kreidler and Conrad 1992, Carter et al. 1995, Harris 1999, all considered the role of the client voice in driving assessment practice, each

highlighting principles of good practice balanced against the reality of delivery of care within a market place economy.

The professional perspective of need was volunteered less frequently by interviewees, than the client and carer perspective of need. Health workers appeared to base assessments on their professional knowledge, experience and expertise moreso than social workers whose initial aim appeared to be to establish rapport and build an enabling relationship, conducive to identifying and meeting needs. As one CPN expressed,

“It is very much based on your professional opinion. During the assessment I would take into account the views and the wishes of the client and their carers but it is a professional assessment. It’s my assessment – people can say to you ‘well I want this and I want that’, but it’s a professional assessment of what exactly their needs are to keep them safely in their own home” (CPN001)

The ability to balance all perspectives: professional and personal, when assessing need was often described as the task or the role of the assessor regardless of professional background. The knowledge, experience and expertise which constituted their professional perspective facilitated the collation of all the information gathered culminating in the identification of assessed need.

The ability to professionally identify needs as objectively as possible and reconcile the perceptions expressed by those involved in the process of information gathering (including those of the assessor) was often identified by interviewees. Part of the skills of a proficient assessor was considered to include the capacity and ability to rationalise the information provided with the resources available.

Professional knowledge of components such as disease progression, service availability, placed some assessors in a position perceived as advantageous: for others it created internal conflict about identifying and responding to need in a satisfactory manner. The sense of identifying

needs and feeling compelled to respond appeared to be deep rooted in many professionals to the extent that few (if any) identified any benefits in undertaking an assessment simply to identify need. For most assessors, assessment was a means to an end with that end involving some form of resource provision. Where that resource could not be provided, the sense of responsibility to meet the need personally within existing professional capacity appeared to be very strong, particularly amongst nurses. One nurse described this process with reference to her own experience,

“I have had situations within my working career that has affected my personal life so I know there is an emotional price tag to pay. I am not unique so if I have paid an emotional price tag, I would expect that most nurses would have paid the same price tag somewhere along the line” (N010)

The time taken to respond to initial referrals was also highlighted as a professional issue with repercussions for the assessment of need. Similarly the ways in which organisations functioned, the values and expectations placed upon their staff and how demands were responded to were identified as areas of professional difference and potential contention. The need to communicate effectively and ensure good interagency working was acknowledged however some nursing staff did describe bureaucratic, organisational barriers which inhibited this. Sometimes it was due to deep rooted organisational values, other times it was accredited to factors as simple as telephone access. The roles undertaken by each professional group might explain the difference in response times. This relates to issues identified by some respondents about assessors being providers; whether direct providers of services or providers in terms of controlling access to services. The nature therefore of the professional role as assessor and provider posed certain time restrictions as one nurse described,

“If we get a referral in, we have to go and see them within twenty four hours. Social work has a longer time before they have to go. If

something crops up with us we still have to see the rest of our patients that day. You can't turn to a diabetic and say 'do without your insulin today because I am really busy' whereas I think social work have got that leeway" (N014)

Currer and Stacey (1986) highlighted that from a personal perspective, people define their needs (in this case their state of health) based on the way it affects their every day lives including relationships with family, friends and work colleagues. Conversely medicine defines health needs in terms of the presence or absence of disease. During the study social workers described a different approach which, whilst acknowledging the impact of disease and ill health, was considered no less caring but much more empowering. A commonly expressed belief suggested that, in the opinion of social workers,

"Nurses do to people whereas social workers do with people" (SW024)

This perception was expressed throughout many of the interviews with social workers who highlighted the need to enable, empower and encourage independence wherever possible. Similar traits were described by Hardina (2005) amongst social work staff. Gomm et al. (1993) argued that health service professionals in particular found the notion of users defining their own needs difficult to accept and as a result they, 'either ignore the prescribed assessment procedures or treated them as marginal' (Gomm et al. 1993 p108). Differences between the medical and social models of care are often cited as the basis of differences in professional approaches to assessment. The distinction is made between disease and illness. Magi and Allander (1981) describe disease as a generic term, which embraces any interference with the normal functioning of the body. Illness on the other hand is a state characterised by suffering or disablement caused by disease and is the experience of the individual. Illness, describes Ong (1991) is both a biological and a social event and is fundamentally socially constructed: the individual must acknowledge subjectively that he or she feels unwell; this must be

confirmed by others such as professionals and social networks. Therefore in order to understand the person's experience of illness and perception of need for medical or social care it is important to pay attention to the disabling consequences of disease.

The medical model has been challenged in literature because it does not take into account the psychological, behavioural and sociocultural dimensions of ill health phenomena. Ong (1991) suggests that within the context of nursing the possible discrepancy between the professional's definition of need and the client's, has to be understood in the light of the opposition between disease and illness. The implications for the assessment of need are, states Ong (1991), obvious: needs must be defined in a co-operative manner resulting from a dialogue between professionals and clients.

At times during the study health services were considered paternalistic, discouraging patients to take responsibility for their wellbeing and independence. The result was often cited by social workers as creating dependency on resources or professionals as opposed to moving an individual from a state of need, through intervention, to independence.

"We approach the person differently. Rather than caring for the person as a health professional might, there would be more of the philosophy of empowerment, helping people, giving people the skills to maintain their independence" (SW004)

With the fostering of independence a priority for social work staff, the relationship between assessment, identified needs and outcomes could be perceived to be different. The process of reaching a state of maximum independence for clients was described by social work staff as involving several components and approaches, some of which were paternalistic in the short-term.

For many social workers interviewed, their ability to assess and address needs adequately was based upon their relationship with the client and

their carer/s. Many described how they felt social work assessments were more holistic because social workers became more involved with the individual and their particular circumstance including family relationships and social history. This process, though time consuming, established a framework upon which information could be gathered from a wide range of sources and a plan initiated which moved the client from a position of need toward a position of independence. How this process was perceived by other professionals and the public in general was also alluded to by social work staff who were aware that an enabling approach did not always ingratiate themselves to others whose concerns centred on needs which they believed ought to be met.

The enabling approach described by many social workers was described as person-centred whereby the perceptions of the client were considered paramount and then those surrounding the client were considered: the professional perspective being used to draw conclusions from the information gathered. One consequence of this approach, raised by nursing staff, was the opportunity to focus too much on the client perspective and disregard the value and requirement of a professional perspective. Concerns were raised by some professionals that social work's emphasis on the client and carer perspective might lead to the neglect of needs that, by nature of risks posed required to be met.

Views were expressed by nursing staff who regarded themselves in the main as more caring, more responsive (in terms of time) and possessors of specialist skills who provide detailed insight into situations. In many cases it appeared that the process of assessment by nurses adopted a more professionally driven perspective compared to social workers who appeared to adopt a client/carers driven perspective'

"I would record what I think as a professional are the needs so I would be taking it from my perspective" (N034)

In terms of outcomes, most professionals shared similar general perceptions i.e. that clients' needs were met appropriately. Despite this

the process of needs identification and subsequent methods of addressing needs did appear to differ between professions. These differences were frequently expressed as opinion by interviewees and ranged from advocating client self-determination to professional dictatorship,

“The public still look for advice and they don't always like modern medicine or modern social work that is all about patient participation and decision-making. People still like the doctor to tell them what to do” (GP002)

Client/patient participation was not included in the study therefore their assumed responses were vocalised by the professional groups interviewed. Most identified that the referral to a professional organisation raised the expectation that a professional response would occur: for many professionals this began with the assumption that the client was unsure what was required and was seeking advice and support. The mechanism of establishing need and subsequent support appeared to be channelled in two areas: supporting the client on a journey of self-discovery and self-determination, enabling them to identify for themselves their own needs and requirements: or the application of professional skills, knowledge, expertise to identify and address professionally determined needs and actions. The two approaches were not mutually exclusive nor did they detract from the professionalism required: both demanded specific and expert skills in order to progress a client through the process of need identification and appropriate intervention. An issue was identified frequently in relation to both approaches: this involved the management of client refusal: either to the assessment process or the recommended intervention/s. If the former approach was adopted then there seemed to be a sense of justification and acceptance of client refusal. If the latter approach was adopted then skills were mobilised in order to persuade the professionally determined outcome. The professional implications with responses to client refusal will be considered in this chapter and others (Chapters 8 and 9), although social workers appeared to favour self determined need identification whilst nursing staff often adopted a professionally determined approach. Both professional groups recognised

elements of these approaches and used them interchangeably: for some interviewees the combination of approaches led to the best perceived outcome for client, carer and assessor.

One GP was particularly concerned about the lack of persuasive techniques used by social workers and compared their approach as paradoxical to that of health staff,

“Social work tends to assume they're saying no unless they've positively said yes whereas I tend to assume they've said yes unless they've positively said no. So it's that slight difference that can cause friction at times” (GP002)

There was a commonality between professional groups about the effect of personal standards or values upon the identification of need. Many interviewees described a process of setting aside personal standards and keeping an open mind.

“One of the first things that this job taught me was not to go in with preconceived notions. My standards are based at a certain level: it does not follow that the people out there have standards at your level” (N017)

Although this was an area mentioned infrequently by interviewees, of those who did verbalise its existence, there was general agreement about the ability of personal views and standards to impinge upon assessment of need. The knowledge of personal values appeared to act as a deterrent for professionals causing them to resist the temptation to impose personal values onto those being assessed,

“Training leads you away from the idea of judging people in any way” (SW018)



### **7.3.3.1 Public Perception of Health and Social Care**

As well as the perception held by professionals towards clients, the perception held by clients toward professionals, was often identified as an area which influenced the assessment of need. The credibility, reliability and trustworthiness of professionals often dictated the success with which an assessment was carried out and acted upon. For some interviewees the notion of trust sparked a discussion about public perception toward statutory agencies.

Often there were discrepancies identified between the way in which the public (particularly the older public) regarded and responded to health and social care services. The general perception offered by interviewees was that health workers were considered more acceptable to older people than social workers. Traditional perceptions of the NHS, the 'Council' or 'DSS' were often blamed for the level of acceptance received by visiting professionals.

"The problem in the West of Scotland is that social work is a bad word. It's partly because health is about healing and there is no perceived shame in being ill. But not coping is often related to why people perceive social work become involved. The perception is that social workers steal your weans, sell your house and put you into care." (SW040)

Whilst this was not only attributed to the public perception of statutory organisations, it also reflected the perceived value system of the older generation served by those participating in the study. Public perception of receiving assistance from a statutory organisation was considered in terms of generational and organisational concepts. The very issue of a professional uniform was raised as a contributing factor toward the effectiveness of the interview and the communication process. Whether the uniform was perceived as a barrier or as a reflection of authority and professionalism was often debated. Most nurses who raised this endorsed

the adorning of a uniform because of the message it relayed to patients: many used this to their advantage particularly when faced with difficult situations.

This was also considered in terms of how nurses internalised their role as that of one as caring and resolving problems experienced by individuals. The particular experience of one nurse, both professionally and personally led her to identify the internal and external influences exerted upon her and nursing as a profession,

“It has influenced me because you want to make things better: you become a Jim’ll fix it: you become like a saviour. I suppose that is how we get called angels – this idea that nurses are angels is because a lot of the time we are trying to solve problems or save individuals from particular issues” (N010)

The prospect of wearing uniforms was rejected by social work staff because of the barrier to communication it might cause and the potential upset to the power/balance ratio. As one social worker (formerly a district nurse) explained,

“I think one of the biggest things that makes a difference is power: don a uniform means and you don an inordinate amount of power automatically. You don't request, you instruct” (SW040)

The notion of an unspoken uniform within social work was raised by a few interviewees, sometimes in jest. Social work stereotypes were sometimes referred to, not always contested, and sometimes considered with regard to the public persona of the profession. As one social worker announced,

“I think people tend to respond to uniforms and ideas of uniforms: it suggests that someone knows what they are doing. Someone turning up in Jesus sandals and wild hairstyles isn’t necessarily going to instil a lot of confidence in someone” (SW024)

However where health staff were described as professionals behind a uniform and social workers as actively avoiding the introduction of anything that might be perceived as a barrier to communication, there was also concern raised that pursuit of a barrier free relationship with clients in order to achieve an effective channel for communication was not always in the professional's nor the client's interest,

"I think there's an illusion that you will have a best friends' type relationships to tease out information from people and I don't think that necessarily is the best way to do that" (SW040)

Indeed the concept of power attached to the assessment process was alluded to by several interviewees. For some, certain 'barriers' were perceived to exist including emotional aspects with respect to the type of relationship created between client and assessor or in other cases, geographical in terms of where the assessment was carried out (i.e. at home or in a 'professional' environment), the presence of a uniform or in some cases the presence of an assessment recording tool.

#### **7.3.4 Identification of Need - Assessment Tool**

Assessment tools were described by several interviewees in response to the question, 'how do you identify needs? This referred to the tool used by professionals to record assessment information which differed from the assessment model, which was used to describe the particular approach adopted to extrapolate information to identify needs. For some assessors there was no discernible difference between the assessment tool and the assessment model: the tool simply being the paper version of the assessment model. For the purposes of analysing the study information the author has attempted to separate the responses made in relation to assessment, recording tools and those which referred to recognised models of assessment whilst attempting to relate this to the ability to be needs-led in their approach to assessment.

For some interviewees the knowledge and existence of assessment tools were regarded as welcome aids to assessment skills and experience, ensuring that assessments were 'more rigorous'. However not every interviewee shared this enthusiasm. Using the example of the multitudes of assessment recording tools, one nurse described this as an infringement on a professional's ability to deliver hands on care.

"We can't even define what nursing is today. One of my colleagues said yesterday 'it is about wiping bums, it is not writing about wiping bums'. I get frustrated with nursing today because we now have tools to fill in about everything: we are writing about caring rather than actually getting out there and caring. And that is maybe the price we are paying for becoming this technological, educated, degreed mob" (N010)

However the role that assessment recording tools played on the actual assessment process was minimised by most respondents. Many recognised the value in structuring and standardising written information but most alluded to the fact that assessment was the result of a process undertaken by a professional assessor as opposed to the completion of an assessment form

"It's only a tool. At the end of the day it's a bit of paper and some ink" (SW019)

One nurse did warn against the use of prescriptive assessment tools which minimised the opportunity to reflect and consider overall needs. Her experience of training nursing staff to use a particular assessment tool left her concerned that prescriptive assessment tools led to complacency amongst nursing staff and a disregard for the role of assessment skills, knowledge and expertise,

"What they (nursing staff) are saying to me is that they have taken the tool and disregarded their assessment skills" (N010)

The need to rationalise time and information was highlighted by nurses during several interviews. Many expressed the belief that nurses stored a lot of assessment information in their head without ever committing it to paper: a trait which appeared to be the converse of social work practice who were more likely to record details to paper. Nurses were perceived to write the necessary, salient points whilst retaining 'mental notes' about clients: an observation made by several authors including Rawlins, et al. 1990, Berkman et al. 1999, Cowley and Houston 2003, Slater and McCormack 2005.

Figure 22 identifies the number of times assessment tools were volunteered during the course of the interviews. The most common response in relation to assessment tools was the Community Care Assessment (or CC1) which at the time of the study was the assessment tool of choice for Glasgow City Council. All social workers used the Community Care Assessment tool to record need and access resources.

Assessment Tools Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Community Care Assessment	0	26	0	2	1
Mental Checklist	10	9	0	2	0
Specialist Assessment Tools	10	3	1	2	0
Risk Assessment	3	8	0	2	0
Over 75 assessment	7	2	0	0	2
Nursing Kardex	5	0	0	0	0
Multidisciplinary tool	0	3	0	1	0
Locally devised tool	2	0	1	1	0
Carer Assessment	0	2	0	0	0

**Figure 22 Assessment Tool: Factors Volunteered which Affect the Identification and Assessment of Need**

Community Care Assessment paperwork had been used within Glasgow for over 15 years at the time of the study and most social workers interviewed could recite the form verbatim and utilised it to structure the information gathering process. The requirement to avoid the rigidity imposed by forms and the perceived barriers that might be created, led many of the social workers to describe the use of conversation without forms as the preferred mechanism to elicit information about need.

Many social workers described the barriers created by written forms whilst trying to establish rapport and trust with clients. The requirement to dispense with formal information recording during initial contact was often cited alongside the need to be open and honest with clients about what information would eventually be recorded, when and why. The use of forms with clients was an area considered secondary by social workers with trust, rapport, relationship building being important in the early stages of information gathering,

"I don't go out with forms on the first visit, I go out for a chat and I'll sit for an hour just talking away and getting to know them and explain 'this is what I'm here for'. If they agree that they want an assessment then I'd say to them 'I'm going to come out and I've got a lot of forms and I'm going to be filling these forms in'" (SW021)

Whilst social workers regularly reflected the need to avoid the use of assessment forms in front of clients, health staff in general seemed more comfortable visually recording assessment elements as these were being gathered. Few highlighted any sensitivity that might be caused to their relationship with the client. For many the use of the form was pragmatic and served the purpose of recording needs and referring onto resources,

"If it was my responsibility to do the assessment, it's too much information for me to remember so I would have to sit with the form in front of me" (CPN011)

The dual assessment purpose of recording needs and supporting referrals was identified by several professionals. The use of written assessment forms with clients was sometimes considered justifiable in light of its purpose, complexity and time requirement. This extended beyond the general needs assessment tool itself and included additional specialist assessment tools and referral forms upon which assessment information was repeated.

Associated with the Community Care Assessment paperwork was a myriad of additional paper tools which were designed to facilitate assessment, service access and care management processes. These were numbered according to the stage within the wider process when they were expected to be utilised. When discussing the Community Care Assessment many social workers referred to the additional forms that constituted the community care process. The separation of assessment, care planning and implementation was made explicit through the use of different forms within the social work community care paperwork: for some social workers this aided the mental separation of assessment of needs and service intervention

The use of assessment recording tools and subsequent care and implementation plans, for some assessors appeared to help maintain a distance between needs identified and resources available although the 'distance' was rarely translated into paperwork practice. The ability to record unmet need within a perceived legislative framework did appear to encourage the process particularly where no resources or inadequate resources existed to meet needs.

However not everyone interviewed shared the connection of a common assessment recording tool. Some nursing staff expressed concern and at times frustration about the use of different forms within and between agencies. The purpose and existence of these forms often came into question and not all professionals were convinced that assessment recording tools suitably assessed the needs for which they were developed.

For some interviewees, the academic and evidenced based development of validated, reliability tested assessment tools have had the negative effect of reducing informal professional to professional encounters where information is shared personally and with specific reference to particular needs. The vast information sharing opportunities provided by 'one to one' professional encounters were perceived to be lost to prescriptive, 'two dimensional' written documents. For some interviewees, the sharing of identified needs on a written format became an excuse to avoid professional contact and cross professional accountability: the result being that both the quality of information shared and professional relationships were reduced.

For many health and social work professionals the assessment tool was based simply on a mental checklist that had been honed through years of experiences. The ability to express the components of this checklist was often difficult but was evident through the process undertaken to identify needs during presentation of the vignettes. The mental checklist alluded to by health and social care workers alike often referred to the models of assessment utilised. Assessment recording formats clearly differed between professional groups with nursing staff often referring to specialist assessment tools utilised in order to enhance or confirm particular components of their assessment.

Social workers highlighted the use of specialist assessment tools to a lesser degree, although their use was acknowledged, albeit as the responsibility of another professional. In many cases nurses would personally undertake the specialist assessment of areas of need such as urinary incontinence, cognitive impairment, and functional ability. Within social work, despite the use of specialist tools to consider areas such as financial assessment, mental capacity, few interviewees explicitly identified these as components of needs identification in relation to assessment tools. Risk assessment however did feature as a specialist component of assessment, usually in the form of a risk assessment tool, endorsed by the employing profession. Social workers referred to risk assessments more so than any other professional group although many



expressed dislike at the additional or specialist nature often attributed to separate risk assessments.

The concept of applying a risk assessment to certain individuals' assessments was considered unrealistic by some interviewees who regarded the connectivity between need and risk as such that any differentiation could lead to failure to appropriately identify needs and interventions. The relationship between need and risk was described by some interviewees as interchangeable.

Many nurses interviewed identified their current needs assessment recording tools. Depending on professional role, the tool utilised tended to vary between the Over 75 assessment screening tool and the Nursing Kardex. The latter was considered the nursing equivalent of the Community Care Assessment and contained common elements of need related to a particular model of assessment. Unlike the social workers interviewed during the study, nurses rarely described the Nursing Kardex in detail other than identifying it as the assessment recording tool used in Glasgow. Few volunteered any concerns about recording assessment information on the Kardex during the course of the assessment: this seemed both acceptable and normal practice: an observation made during similar studies (Morrison 1989, Kennedy 2004).

The use of other assessment tools such as multidisciplinary tools and locally devised tools was described by only a few respondents. In the main these were developed to consider and address needs specific to certain conditions e.g. mental health. Most assessors agreed that forms helped to structure the assessment itself, whether that was formally or part of an informal conversation or a semi-structured interview with note taking.

Finally whilst the majority of interviewees identified that the carer depicted in the vignettes was experiencing many and varied needs, few volunteered a carers' assessment as an appropriate way to identify these needs separate to the client's needs. At the time of the study, the profile

of carers needs was rising across Glasgow with a programme of carer needs assessment training in its early stages. Few assessors consciously considered the need for a carer's assessment although they did describe the carer's needs through utilisation of the same assessment skills applied to the client.

### 7.3.5 Identification of Need - Experience

In response to the question how do you identify needs, many professionals described their particular experience as a key component in shaping the ways in which needs were identified, information gathered, and action taken. Within discussions about experience several components were raised and these are outlined in Figure 23. Many referred to their professional training whilst considering experience: few described experience without alluding to the effects that professional and in house training exerted upon their assessment skills in general.

Experience Elements Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Professional Experience	32	25	5	3	2
Anticipate Future Needs	10	20	2	4	2
Training	17	21	0	1	0
Knowledge of Service Options	17	13	3	2	0
Knowledge of Disease Process	7	12	0	1	0
Personal Experience	8	7	2	0	2

**Figure 23 Experience: Factors Identified which Affect the Identification and Assessment of Need**

Professional experience was often used to describe the combined skills distilled through training, practice and learned expertise. There appeared to be no end to the factors that influenced and shaped people's

experience. Organisationally, professionals operated within a value system whose culture was readily adopted and applied in practice. Chapters 8 and 9 will examine the extent to which this impacts on the assessment and ability of professionals to respond. However the majority of interviewees, when discussing the role of experience in the assessment process related this to professionally gained experience and described how this impacted upon their ability to be needs-led.

Figure 23 illustrates the professional responses volunteered for each of the areas. Nurses were more likely to reflect on the role professional experience had on assessment practice and needs identification. Similarly nurses cited more instances of in-service training and professional development opportunities within their employing organisation than their counterparts in social work or housing. However not everyone interviewed exalted the benefits of professional experience,

“I don’t think experience means you improve. You may reach a point where you make the assessment based on past experience that isn’t necessarily the experience of these people or true for these people. So it’s maybe a bit presumptuous to say that because you have got a lot of experience that you are actually a good assessor” (N019)

The utilisation of experience and knowledge of disease progress to facilitate anticipation of future needs was also a component frequently referred to by health and social work staff alike. Whilst the components which caused assessors to draw particular conclusions were often based upon their experience of similar scenarios, the awareness that not all experiences were generalisable was often alluded to. Nevertheless the influence this exerted upon the assessment process was undisputable, particularly in relation to needs-led assessment.

Social workers also alluded to their professional experience of similar scenarios and the skills used to pre-empt needs which might arise. Awareness of these factors helped them prepare for potential events and support families through the various stages of disease progression and

the needs which they had come to associate with each stage. Lack of experience of similar situations, conditions or circumstances, for some, was considered a disadvantage although the application of general assessment skills appeared to universally support assessment of need.

The requirement to be proactive as opposed to reactive with the knowledge of predictable breakdown in care was an area raised by several nurses when discussing their experience,

“Your experience with whatever illness is really important. When you see an illness you can see all the problems. You can see their needs and the problems about trying to get different services in place. And really I think ‘right start the ball rolling now rather than waiting until it’s actually an emergency’” (CPN009)

Anticipating future needs related not only to the needs experienced by the client and the carer but the needs generated by organisations whose perceived resource restrictions required the referral to services in advance of certain needs presenting themselves. This was a trait identified within health staff more so than social work staff.

The identification of need by all professional groups tended to take into consideration future requirements. Needs were rarely identified in a time vacuum but were considered with understanding of past ability and predicted future ability. Social workers sometimes referred to short or long-term goals which were identified mainly with clients and their carers. Despite anticipating future decline, social workers appeared less likely to mobilise services early in anticipation of avoiding resource delivery delays. A knowledge of resources and their availability appeared to be neither a deterrent nor an incentive to mobilise resources in advance of or anticipation of a crisis occurring. This is not to say that resource referrals were not made in advance of needs occurring but resource intervention was rarely raised as an option in identifying and addressing long-term or anticipated needs.

Social workers more so than nursing staff referred to the need to respect the client's and carer's wishes in considering future responses to anticipated needs. Nursing staff sometimes expressed awareness that social work adopted this approach and were reluctant to refer to social work unless client and carer compliance was established, although at times the risk associated with need superseded the question of compliance. Some interviewees described the process of assessment as a means to an end with one nurse describing her experience of social work,

"Social work - usually they don't want you to make a referral for an assessment because they then have to do a great big assessment at the end of which people refuse everything" (N016)

The urgency with which certain needs were perceived did lead some interviewees, particularly in health, to actively encourage service intervention. For many, experience taught them that client refusal often led to breakdown in care which resulted in service intervention regardless of client compliance. The frustration this caused was evident across professional groups; however the extent to which client choice dictated practitioner action was particularly poignant.

For some the experience of a similar situation within their own domestic life meant they could empathise with the couple depicted in the vignette and were able to exercise a degree of insight into the issues experienced by clients and carers. Some interviewees with personal experience of similar issues described how they actively utilised those experiences within the assessment process. Where it was considered safe and appropriate, some assessors shared their personal experiences with clients, believing this to increase the sense of trust, rapport and credibility with the client: components previously identified as critical to effective communication,

"I was a carer for a long, long time: I cared for my mum until she died last year. And these are things which I use because it's about the power balance" (SW019)

Where the sharing of personal experiences was volunteered during the interview, it was mainly by social work staff and was described with caution. The 'power balance' alluded to by the previous social worker was often considered a precarious balance, easily swayed by changes in condition and circumstances. For such reasons the sharing of personal experiences and information was undertaken with the knowledge that the client/professional relationship could be compromised, a factor which several nurses referred to with caution.

The ways in which personal experience impacts on the assessment and needs identification process and 'colours' professionals' interaction with clients included many other references to potential life experiences. One social worker noted that,

"It depends on your own theory and value base as much as where you come from" (SW021)

Some interviewees identified that sometimes they would change their accent slightly, enhance their Glaswegian dialect, change the language they used, dress to 'match' their client group in order to fit in and establish trust and build rapport with the people being assessed. Some interviewees described their ability to customise their methods of communication dependent on the situation or individuals they were dealing with, as a communication skill that facilitated their relationship and professional credibility with clients. Occasionally interviewees made reference to the cars they drove: deliberately driving a car that would not be considered extravagant or pretentious when dealing with clients on low incomes, living in deprived neighbourhoods. One social worker however did describe this deliberate exposure aversion as an act of arrogance in itself,

"I have heard a social worker saying 'I don't want to drive into Easterhouse where folk feel as though I am rubbing their noses in it'. There's an arrogance there because it assumes that people don't realise they earn a good wage" (SW040)

Experiential aspects therefore appeared to impact on the assessment process to a wide and varying degree with some interviewees exercising more cognisance than others. The extent of these influences and personal choices for some reached farther than interview time would allow,

“There’s an awful lot of personal, experiential stuff comes to bear. There are lots of subtle influences: your own family, your own upbringing, religious influences, any kind of cultural norms” (SW018)

One influence identified by several respondents across professional groups was that of training. Training undertaken in order to establish an individual as a professional within a recognised discipline was highlighted as a factor which affected the way in which needs were identified and assessed. For several professionals interviewed, training provided the framework upon which they were able to build their practice,

“When you complete the social work course it’s really only like getting your drivers’ licence: it’s a bit of paper but then your real training begins when you go out there and you start doing the work” (SW019)

The value assigned to the basic professional training varied across the study sample. The majority of interviewees were tokenistic when describing the role that professional education played upon their ability to assess and meet an individual’s needs. For many the role and task of assessing became internalised following professional training and was honed by experience. For some the value lay not in their own ability to assess needs but in the credibility that professional training gave them as perceived by those in receipt of their skills and services.

Not all nurses were enamoured by the professionalism that academic training brought to role of the nurse. The vocational versus the professional perspective of nursing was raised several times and the perceived move toward scientific academia away from ‘hands on’ caring

was a source of concern for one nurse in particular who articulated her concerns throughout the interview,

“I think what your training does is make you be aware of what is instinctive. I believe nurses come into nursing with that in them and that gets honed through their training. My concern is that if they go purely academic we are actually taking away from the intuitive aspects and the things that intrinsically make us good nurses. Nursing beforehand was unscientific but what is scientific about caring, about going out and meeting a person and supporting a person and yes washing them if they need washed or listening to them if they need listened to – what is scientific about that? That is human interaction – if we need to get so scientific about that then we have to ask ourselves how do we actually interact with one another in a course of a day?” (N010)

The argument is also made that the requirements enforced to ensure caring organisations remain professional i.e. that certificates, degrees and in-service training are prerequisites then a section of society are marginalised: those on low incomes who might be capable and competent at caring are denied access to courses because of societal restrictions and poor opportunities, (financial or otherwise). Whilst this was a view expressed by a minority of respondents it did extend the scope of the debate initiated around the vocational nature of caring professions, their reception by the public and the factors (academic or otherwise) which contribute to the assessment of need. Given more time, this was an area that could have been explored further with more interviewees.

### **7.3.6 Identification of Need - Assessment Model**

When asked to describe how needs were identified, some respondents highlighted the use of particular assessment models. Whilst Chapter 8 deals with the specific components of assessment, this section relates the particular model of assessment to the identification of need as volunteered by respondents early in the study interview. Chapter 8



concentrates on a more detailed discussion and analysis of the definitions of assessment as perceived by interviewees. Sometimes assessment models were linked with the assessment recording tool used, as many models were accompanied by paperwork which allowed the systematic recording of information gathered as a result of applying that particular model. Figure 24 identifies the models that were volunteered by interviewees.

The use of models was a particular area where differences were noted between professional groups. The majority of nurses interviewed made reference to Roper, Logan and Tierney's model of ADLs. For some the mention of ADLs was in conjunction with assessment recording tools therefore information was coded in the way that practitioners perceived and presented their knowledge of assessment models. Very few social work staff made reference to the ADLs: those who did were amongst the group with dual training. Many social workers were explicit and adamant that no model was adopted and that needs were identified as a result of their professional knowledge and skills.

In total, 28 models were identified however many were only described by a few interviewees: only those identified more than once are recorded in Figure 24. Of particular interest was the fact that models of assessment were later described by interviewees as factors which influenced the assessment of need and subsequent ability to be needs-led.

Assessment Models Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Activities of Daily Living	18	1	0	2	2
Roper, Logan, Tierney	11	0	0	5	0
No Model	0	14	0	1	0
Whole Person Approach	4	6	0	1	0
Holistic	2	3	0	0	0
Mixture of models	1	2	0	1	0

Assessment Models Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Maslow	0	3	0	0	0
Orem	3	0	0	0	0
SPIRIT	0	0	0	2	0
PIES	1	1	0	0	0

**Figure 24 Assessment Model: Factors Identified which Affect the Identification and Assessment of Need**

The use of Roper, Logan and Tierney's, ADLs was commonly expressed as the assessment model adopted by nursing staff within the sample group. Most had been trained in its use during their professional education and applied the model in practice including recording materials which supported the reporting of needs related information in the format of the model of assessment. When describing this model, interviewees gave little consideration to its influence, purpose and effectiveness: its use appeared to be an accepted aspect of nursing practice. Few nurses questioned other alternative models but reflected the fact that since nursing assessment paperwork supported that model then that was the model they applied, despite being aware of and having skills to apply others.

The use of an assessment model appeared to provide a professional framework upon which to build experience, knowledge and expertise. The benefits of adhering to a prescriptive assessment model and recording tool were highlighted in terms of supporting new members of staff and also standardising information collected and shared with those involved in a client's care. The degree to which the application of assessment models such as ADLs, became intuitive was clear from the majority of interviews.

Assessment models were also described by interviewees as a defining difference between health and social care professionals as both utilised different formats and styles.

"I think social work are more person-centred: they look at the bigger picture. If you could get some social work reports and show them to district nurses and see what district nurses write on the Kardex, they would be amazed. The Kardex paperwork limits the nurse to only a couple of lines although I don't know whether district nurses have got time to write more" (N009)

The issues raised earlier in relation to the potential for the assessment recording tool to dictate assessment practice appeared to also be true for the assessment model adopted. The limitations of prescriptive assessment models appeared to restrain nurses from recording (and perhaps gathering) more extensive information pertaining to individual's needs.

"I would record what I was going to provide: I would have to break it down into what the areas were, and I'm sorry to say it, tasks: that is the way it would be recorded and that is the way it would be dealt with" (N019)

The power assessment tools and models exerted over the assessor with regard to the approach adopted in identifying needs was evident. As indicated above the assessment model and recording tool utilised led to the identification of need and resource requirements as a combined aspect of the assessment process. The model did not appear to facilitate the separation of needs identification from care planning and implementation but instead combined the two aspects leading assessors to identify service outcomes as they identified needs. Similarly the tasks perceived to be required were identified as a consequence of applying the assessment model and recording simultaneously on the assessment recording tool.

The tendency of social work models to centralise the client and carer's perspectives and wishes was also highlighted in comparison to health models which appeared to be more professional in their perspective. This is not to say that this approach directly contradicts that adopted by health professionals but often the focus was different,

"We have categories in our mind so I tend to do what I did as a student. Back at college we were taught in what is called a systems theory: the theory is that everything links into the person's managing and their functioning" (SW010)

One difference identified by several interviewees was the perceived lack of a common assessment model by social work. Despite being trained in a myriad of models of assessment, most social workers described their assessment practice as unique to themselves, drawing upon skills, knowledge, experience, expertise and a combination of assessment models for the assessment at hand. As a result there was little standardisation or commonality between the assessment models adopted by social workers who participated in the study although the principles and proposed outcomes of the assessments remained the same: essentially the process differed due to personal, professional customising. One social worker explained,

"In nursing there is rigidity, and within social work there is the complete opposite in terms of how they assess. Although social work have forms to fill in there is an almost laissez faire attitude around: assessment is very subjective because it is around what they personally perceive. I would wager a months salary on it that if you asked ten social workers what theories they use to underpin their assessments, nine or ten couldn't tell you because they have consolidated these theories into everyday practice: it is unconscious. And nurses do the same but in a different way because they use the rigidity of the forms and the fact that it is an accredited or verified tool as their get out. It is almost as if the tool becomes the skill rather than the skill informing how you complete the tool" (SW040)

The perceived extremes of assessment as a learned skill or the outcome of an applied process was raised throughout interviews and often expressed as a component which defined and distinguished health and social care professionals. The subjectivity with which assessment was embraced within social work did appear at odds with the professional

objectivity apparently endorsed within health professionals. The ability to measure things, diagnose and treat conditions in health was often used as a metaphor for their approach to needs assessment with the caveat being that not all needs could be met or were chosen by the client to be met. Professional acceptance of client choice therefore was never far from discussions about models of assessment. This for some professionals began with an evaluation of their own belief systems and ability to separate that from those being assessed.

“People who were trained in social work seem to have gone through a process whereby they have had to look at their own values and re-establish their own self and values so it just becomes an intrinsic thing. Whereas people that haven't been trained to identify and set aside their own personal values like that will tend to be working more from their personal valuation points” (SW023)

For many social workers, the concept of utilising a model of assessment meant an eclectic approach to a combination of models, tools, skills and resources at their disposal. Models were considered moreso in the context of their professional assessment skills as opposed to their assessment skills being applied to assessment models. Some social workers therefore favoured mixing and matching a combination of assessment models in order to undertake the process of assessment. The majority resisted the rigidity which assessment models and tools appeared to apply to the process. This is evidenced in social work specific literature which highlights the centrality of the person and their views of need, the professionals' ability to elicit that information and the capacity of organisations to enable and/or address need (Percy – Smith 1996, Smith 2001, Weinberg et al. 2003).

## **7.4 Chapter Conclusions**

A shared definition of need is considered fundamental to the successful implementation of the objectives of the Community Care Act (1990) and yet the term 'community care', ubiquitous in our vocabulary, has been

accepted by politicians, policy makers, professionals and the public, apparently without clear or concise definitions for many years. The result is described:

“To the politician it is a useful piece of rhetoric, to the sociologist it is a stick to beat institutional care with, to the civil servant it is a cheap alternative to institutional care, which can be passed to local authorities for action or inaction. To the visionary it is a dream of a new society in which people really do care; to social services departments it is a nightmare of heightened public expectations and inadequate resources to meet them. We are only just beginning to find out what it means to the old, the chronic sick and handicapped” (Jones, Brown and Bradshaw 1983 p114)

Defining need within the context of community care reflected the professional's perception of the opportunities or challenges presented by this policy. The concept of need verbalised during the study, uncovered a myriad of perceptions, often unchallenged by other professionals.

The concept of need as defined by interviewees during the study identified relatively common themes. This chapter has focussed on the main several elements including reported definitions of need and factors affecting the identification of need. With respect to the definition of need, this was ultimately based upon perception and identified as a subjective concept. Need as a perception was therefore the most frequently cited definition, followed by need as a requirement or a deficit. The two latter descriptions were at times used in conjunction. Where need was identified as a requirement there was often a focus on the type of intervention required including resources. Less frequently cited definitions of need were described however discussion about their use and relation to relevant literature was minimised. Therefore the more functional definitions of need considered elements such as 'coping with daily life', 'independence', 'quality of life' and each professional group identified components within each which supported their conscious and subconscious concepts of need. For some interviewees, need was

described as the end product: the service intervention. Of those who described need as a service requirement there was a sense that several steps were combined into one leap from needs identification to outcome. Some interviewees utilised existing models and concepts of need including Bradshaw, Maslow, Roper, Logan and Tierney. These provided assessors with a structure upon which perceptions of need could be constructed, identified and recorded. This was of particular importance when needs were distinguished from desires of wants.

Identifying the factors that facilitate the identification of need for interviewees and support their assessment provided unique insight into the decision-making processes which culminate in the common concept known as need. The second part of this chapter focussed on the factors that help assessors identify need: three main areas were identified: communication, information gathering and perception. With the general purpose of identifying needs most practitioners highlighted the importance of communication skills and approaches. The information gathering component of needs identification involved a variety of methods and mechanisms whereby the right information was sought to make an accurate interpretation of the situation and the particular needs. Finally the area of perception was again considered with the same emphasis placed on the ability to combine client, carer and professional opinions in order to reach a common, sometimes compromised interpretation of need. Perception this time also considered the public's perception toward caring agencies and their willingness to receive support. Professional differences were noted and described.

In general the general components identified by each professional group, whilst representing common elements, did highlight some differences. The extent to which the information gathering exercise was extended within social work, the value attributed to the client and carer's perspectives, the application of assessment tools, knowledge, models, experience, training and expertise all featured as factors influential in identifying need.

The linear continuum of need and needs assessment/identification appeared to be described more commonly by nursing staff and was cited less frequently by social work staff who seemed to favour a more interwoven approach drawing upon a variety of sources and communication methods. Myers and MacDonald (1996) describe an imbalance in perceived authority not only because of professionals' knowledge base but due to their power to access resources. Caldock (1994b) argues that terms such as need and care place clients in positions of dependency. Similarly Walker (1993) argues that case or care management tends to regard clients as being managed and sees the needs of older people negatively in terms of dependency. Middleton (1994) suggests that assessments, rather than starting with the hopes and aspirations of clients and carers tend to focus on deficits and difficulties. McWalter et al. (1994) identify that while this is a necessary component of assessment, a more holistic approach is required. This should build on strengths and coping strategies rather than undermining them (Nolan and Caldock 1996).

One aspect common throughout the study sample group was the complexity and interconnectivity of the identification of needs. Components were difficult to deconstruct because each influenced or was influenced by another. The commonly held belief that a person-centred approach should be adopted was often highlighted with constant references made to the individual at the centre of the process as opposed to the professional. The purpose of the process of identifying and assessing needs should, many argued, not be lost in academic arguments about models, processes and tools.



## CHAPTER EIGHT

### 8 ANALYSIS OF DEFINITIONS OF ASSESSMENT

#### 8.1 Chapter Introduction

The purpose of this chapter is to consider the definitions of assessment volunteered during the study. The main categories have been outlined and coded from the interviews and each category is considered within the following sections. The first three main categories will be considered in most detail with reference to relevant literature. Figure 25 depicts the definitions as volunteered by interviewees.

Definition of Assessment	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Identification of need or problems	25	29	2	7	1
Information Gathering	17	23	2	3	0
Meeting Needs	14	10	3	1	1
Picture	6	16	3	3	0
Interpreting information gathered	9	10	2	0	0
Process	7	10	1	1	0
Perception	7	8	1	1	0
Identifying service solutions	4	9	0	1	1

**Figure 25 Definitions of Assessment Identified in Study Sample**

Assessment as an activity was considered in relation to need and during the latter stages of each interview; respondents were invited to present their own definition of assessment. It is from responses to this question that categories were identified and conclusions drawn. The relation to

need and methods of identifying need described in Chapter 7 is supported by the insights provided into how interviewees conceptualised need.

Whilst interviewees struggled to express a definition of need in words, when asked to define assessment, most were able to describe the complex elements which they perceived constituted assessment. Most described assessment as the process of identifying needs although descriptions were rarely short or concise but reflected a myriad of factors. Definitions reflected perceptions of assessment as both a process and task.

Extension of the concept of the 'norm' re-emerged and clients were identified as deviating from or, through a process of support and rehabilitation, redirected toward relative normality. This concept was critical to the perception of need identified in Chapter 7. The perception of a norm as a deviation from an accepted, though not quantified average was highlighted by several interviewees: for some this was identified by the client and/or carer. For others, the norm was a professionally determined concept. Regardless of their perception, assessment was based upon a description of the degree to which individuals had strayed from this norm

### **8.1.1 Assessment as the Identification of Need or Problems**

The identification of needs and/or problems was the most frequently cited definition of assessment. The ability to utilise skills, experience and expertise to identify needs in general appeared to constitute the complex area referred to as assessment. For some interviewees, the identification of need was the beginning and ending of the assessment component which in itself was a part of a much wider process,

"An assessment is just the ability to perceive the needs: that doesn't mean that you're going to address them but you are picking up the needs" (GP001)

Many interviewees suggested that the definition of assessment was based upon a definition of need which highlighted a requirement for some type of intervention and was necessarily outcome focussed.

“Assessment is an examination of what assistance is required”  
(N022)

The extent to which multiple perspectives impacted on assessment was clear as people described how they would define assessment. Part of assessment appeared to be the ability to collate multiple perspectives into a meaningful representation of a person’s needs. The value in incorporating multiple perspectives of need was identified as producing a more holistic assessment of the situation and providing an estimate of the acknowledged ‘norm’ against which needs were determined.

The perception of assessment contributing to a plan of action that involved interventions to alleviate needs was often alluded to. The requirement not only to identify needs through the course of the assessment but to indicate the level and type of resource implication was apparent amongst all professional groups. In some instances goal setting was a natural step beyond assessment with interviewees assuming responsibility for goal setting or care planning in conjunction with needs assessment. The setting of goals, whether achievable or not, allowed assessment related activity to begin and moved clients away from a state of need toward a needs met status, which for many interviewees appeared to be their primary motivation.

Resource intervention was rarely far from descriptions of assessment as was the case with need; most assessors regarded the process of assessment as a means to an end where the outcome frequently included the intervention of services. Identification of need, as a definition of assessment often reflected the outcome, as needs were described in service terminology. For example a need for assistance with homecare might be described directly as a need for a home help service. Arriving at a service conclusion seemed based upon a lengthy process utilising a

multitude of skills, knowledge and expertise. Interviewees raised resource issues early in the assessment process. The notion that needs were identified as gaps in a person's ability to cope, function or manage everyday life with or without resource intervention featured amongst many definitions of assessment in relation to the identification of needs or problems.

The validity of written assessment material was considered amongst interviewees who described the written assessment as a snapshot in time of a person's needs upon which an evolving care plan was initiated. This was a view equally represented amongst those interviewed, as was the perception that the identification of need (as a definition of assessment) was one component of a much larger, complex process, beginning with assessment,

"Assessment is identifying what need is, so you are having to evaluate along some sort of acceptable scale so you can identify that patients have needs. Assessment is that great big umbrella that looks at all of the points" (N001)

A recognisable difference between health and social work staff was evident within the information gathering component of assessment. Social workers appeared to thoroughly investigate background information, including the perception of those involved with the client and/or carer whilst completing an assessment of need. This often lengthened the assessment time and created more of a pen picture description of a person and their particular situation whereas nursing staff reported restrictions on the time available to complete an assessment. Nursing assessments of need were often completed more quickly with less input from others involved in the support and care of the client. Both professional groups described the utilisation of similar assessment skills, tools, knowledge and experience however the timescales within which these were applied did vary between the organisations.

Assessment models also varied between assessing professionals. Almost every nurse interviewed referred to Roper, Logan and Tierney's ADLs as the assessment model adopted whereas there was little consistency in the models described by social work staff who appeared to have access to a myriad of models used only as they considered professionally appropriate. The resultant model of assessment described during interviews with social workers often involved an amalgamation of models determined by experience and expertise.

Time was also a factor in determining outcomes of assessment as was the process of information gathering during the assessment itself. Nursing staff frequently referred to their dual role as assessor and care provider, with the latter being perceived as more critical. Whilst assessment preceded every clinical activity undertaken with clients, nurses often referred to the assessment of need as a more holistic aspect undertaken in particular situations, more often by professionals with a specific remit for assessment and care management. Therefore social workers were often described by nursing staff as the professionals best placed to undertake an assessment of need which was likely to result in resource intervention and ongoing support and review.

Access to resources was an area described during interviews as distinguishing health from social work staff. The perceived distance and inability of health staff to directly access existing resources led to the responsibility to both assess and address needs being transferred to social work staff. Whilst it was recognised by interviewees that each discipline had the capability to assess and appropriately address needs, levels of resource access and authorisation prevented health staff from undertaking this component of care and support. Responsibility to appropriately address needs was therefore transferred to social work staff due to organisational directives and imperatives.

Resource awareness and perceived responsibility to access services led to differences in perception of the level of support required by an individual and their carer. This was identified in relation to the extent to which they

were perceived to be in need or at risk. In such cases the author made certain observations between professional groups whereby social work staff tolerated and were supported organisationally to permit higher degrees of risk than was considered acceptable by health staff within the sample group. Whilst most interviewees considered the couple depicted within the Vignette to be at risk, the degree to which this merited a resource response differed. Nurses were less tolerant of risk and responded in a risk averse manner whereas social work staff were more relaxed about the degree to which client's understood and accepted the level of risk they experienced. Organisations appeared to support professionals within these perspectives.

The degree to which professionals operated autonomously and had the ability to reflect and be challenged about their everyday assessment practice also appeared to differ. Nursing staff operated almost completely autonomously despite being part of a wider team: little or no opportunities were described where nursing staff were formally facilitated to reflect on practice on a case by case basis in order to enhance practice. Social workers alternatively, through the process of supervision, were accustomed to reflecting on practice, challenging their own decision making and being challenged by others about their rationale for decision making.

The process of identifying need and then determining ways of addressing that need appeared to differ between professional groups with social workers describing not only a heightened awareness of resource availability but also an awareness of resource restrictions in relation to waiting lists, eligibility criteria, funding and mechanism of access. Some nursing staff interviewed expressed little or no awareness of the process by which resources were identified, justified, accessed and reviewed. For some nurses, resource access involved referral to appropriate agencies with the expectation that responsibility to identify and access the most appropriate resource would be accepted and actioned.

One aspect which evaded many health, housing and social care interviews was the breakdown of the stages within which assessment operated. Few made explicit reference to assessment being part of a wider cycle of assessment, planning, implementation and evaluation. In the majority of cases, assessment was the mechanism by which needs were identified, resources agreed and accessed, and where appropriate care and support reviewed. Assessment appeared to embody a myriad of complex processes which in theory are deconstructed into separate entities. There was a general perception that the practice of assessment led to several shortcuts whereby needs were identified not simply by their description, but mainly by the mechanism through which they ought to be met.

### **8.1.2 Assessment as Information Gathering**

Many interviewees defined assessment as the process of information gathering which led ultimately to the identification of need. Often the components of the information gathering process were listed and these incorporated professional, personal, organisational, client and carer perspectives. Interviewees from health and social work services alike identified the requirement to collect information from multiple sources yet recognised potential professional differences in perspective.

One common component identified was the mechanism by which information was gathered: many interviewees referred to the utilisation of all of their senses and abilities to gather, record and report assessment related material. These included general observations, interview techniques and assessment tools and covered every conceivable approach available to professionals to gather information considered pertinent to the assessment process.

“Assessment is finding out what their needs are: a series of observations and questions” (N005)

Data collection though a complex process of information gathering was aimed at a common goal: for some interviewees this involved a

description of needs: for others it involved the description of resource requirements. The focus of assessment in practice appears to concentrate on that which is obvious (Farrell 1991, Worth 1996, Green 2004, McWalter et al. 1994, Sheaf et al. 2002). Concentration on physical problems is a common criticism and may be accounted for in terms of ease of identification and existence of successful remedies. Ellis (1993) identified an increasingly significant shift towards the targeting of resources by local authorities on the grounds of basic survival as opposed to quality of life needs. While issues regarding quality of life are considered important to any caring profession, it is an aspect which remains elusive and intangible. Attempts to measure 'quality of life' phenomena are applied widely in Public Health Medicine particularly when decisions regarding cost and efficiency are made in relation to procedures affecting populations. The role of quality of life considerations in needs assessment has attracted much attention from purchasers of services who must make informed choices regarding 'needs for services'. As rationing becomes a popular issue both politically and professionally, quality of life factors may provide a counter balance to the needs-led economy of care.

Often the components of assessment and care planning were interlinked and both featured frequently in respondents' definition of assessment. The ability to plan care appropriately based upon information gathering appeared a motivating factor of the assessment process across professional groups.

The importance of perceiving need from the perspective of the client was highlighted by interviewees whose definition of assessment was based upon the client/carer perspective. This was more evident within social work staff although nursing staff did allude to the consideration of personal perspectives. For some, the process of gathering information regarding personal perspectives required some form of standardised framework through which information gathering was formalised. However others highlighted that though a recognised model or framework underpinned practice, the gathering of information was perceived as an informal interaction between professionals and clients with professionals



keen to continue this. The formality of recording assessments in a standardised manner was referred to more frequently by nursing staff although social workers did present instances where their assessment models or tools guided the recording of information. Often it was unclear as to how guided assessors were by the written material or whether it was simply used as a way of recording information that had been collected through the process of assessment.

The purpose of assessment appeared crucial when multiple perspectives were incorporated. The aim to reach a consensus and where appropriate a consensual outcome was often reiterated as a motivating factor. Not all interviewees described the inter-relational components of information gathering but identified components of a structured format resulting in assessed need. Some described the information gathering process as very formal and pragmatic,

“Assessment is a study of a patient's behaviour and their condition, their lifestyle, health: an in-depth study of their health” (N002)

Whilst assessment may result in an outcome, when the focus was on the information gathering component, the outcome was rarely volunteered but was discussed by interviewees with prompting. The process of information gathering was described by health and social care professionals as requiring all their skills in order to reach conclusions about need and/or interventions.

One aspect often alluded to was the limitation of a written, static assessment: some interviewees considered it a snapshot in time: a description of a person and their needs at the point of assessment. Whilst the process of information gathering was defined as a dynamic one, the recording of assessment in some respects reflected a ‘still life’ of the client and their situation.

Some interviewees progressed this theme and considered the implications for practice particularly in the move toward meeting needs which were

rapidly changing. The links from assessment to care planning were described as contemporaneous. The requirement to capture information relating to need was seen as limiting the length of time during which any assessment of need was valid. For some interviewees the reality of managing non-static need often led to the acceptance of a general overview of the person and their situation with a view to addressing needs in an evolving manner, anticipating outcomes through the application of experience both academic and practice based.

“My definition of assessment would be to gather all the components of the main picture: the sum of the parts is greater than the whole”  
(N028)

The reality in some situations therefore meant that needs were being met as other needs were being identified. The notion of a continuum containing assessment completion, care planning commencement and then resource implementation was not always perceived as a logical progression in practice despite its justification in theory.

Words used to replace assessment included reference to the activity and the purpose: the use of terms such as examination, evaluation, consideration were not uncommon. In addition the assessment of issues was also raised with a minority of interviewees across disciplines referring to elements of disability, disease, infirmity, capacity. Some assessment models encouraged professionals to consider assessment of need in terms of building capacity therefore negative terms were avoided by interviewees and replaced with constructive vocabulary reflecting the policy and practice move away from disability to enablement. Regardless of vocabulary, the concept of assessment was defined as information gathering and recording in practice based language.

### **8.1.3 Assessment as Meeting Needs**

Some definitions of assessment centred less on the process of gathering information to identify need and more on the process of meeting the need

i.e. were more outcomes focussed. For many health and social care professionals, assessment was undertaken with the intention of suitable response recommendations, therefore assessment as a mechanism of meeting needs featured strongly in their definitions.

Ability to respond to needs, mainly by directly addressing or arranging referrals was suggested by interviewees in relation to definitions of assessment. This reflects the processes yet to be described in Chapters 9, which considers the factors that influence the extent to which needs could be met. The complexity of the process of assessment was described by some interviewees as incorporating many of the factors described in Chapter 9 with continuous consideration as to whether needs could be met within the current climate. Knowledge of resource availability and access appeared to influence the assessment and the response to the assessment. The role of factors identified as influential to the assessors' ability to address needs seemed to exert a pressure from the outset as well as the outcome for many assessors.

The general concept of assessment was described similarly by health and social work staff, particularly in relation to addressing need. Mechanisms to meet needs were described by interviewees to include a variety of resources such as equipment, services and individuals. In some cases meeting needs was described very specifically such as an action required of certain services, professionals or individuals. For some interviewees, the act of meeting needs was the component which defined assessment.

"Assessment is to establish the need or problem: 'what can I do to help, what can someone else do to help, who needs to be involved in order to solve this problem or ease the problem?'" (N040)

Meeting needs was frequently defined in language describing professional interventions however many interviewees were keen to reassert the partnership approach undertaken to assess and meet needs. Whilst the professional was equipped with the specialist knowledge to suggest and/or determine resource interventions, the meeting of need was often

encompassed within a professional/client partnership approach. The process of translating the identification of needs into a satisfactory outcome for both client and assessor was described by interviewees as an integrated process. In a small amount of interviews, care and support planning was recognised as distinct and discreet entities following assessment. Where this occurred, care planning involved a translation of information gathered into a series of options and interventions which were then considered to address needs.

Assessment in many disciplines is treated as a stage within a wider process: that process being a cycle of events, each stage impacting upon the next. In a nursing context, the Nursing Process (Yura and Walsh 1988) provides the conceptual framework for models of care. Clarke (1990) describes the Nursing Process as being concerned with individualised and total patient care: 'individualised' describing patient centred, 'total' embracing the physical, psychological, social and spiritual elements. Ong (1991) states that one of the biggest issues in nursing is that the theory of nursing models promotes the idea of holistic assessment yet the reality of service provision is far from holistic.

Essentially the Nursing Process has four sequential dimensions: assessment, planning, implementation and evaluation. The process recognises the relationship between each stage and the importance of order within the cycle. The same exists within social care where assessment is seen as a stage within the care management process. The key factor between the identification of need and implementation of care, is that of care planning or objective setting. The care plan has been described as providing continuity: an even flow of care from one professional or profession to another. Because the process of assessment is reflective of the context within which it exists, personal, public and political agendas can compromise the focus. Marshall (1990) suggests that:

"assessment is not something that ever exists on its own but the word should always be followed with 'for what'" (Marshall 1990 p36)

When the 'for what' aspect of assessment becomes the motivation for the process, the performance of the task itself can encroach on the territory of care planning. Planning on an individual basis necessarily involves several stages: aggregation of collected information: identification of needs (both met and unmet): needs priority setting; formulation of goals and objectives: and design of strategic intervention (Potter and Perry 1987). Nolan and Caldock (1996) suggest that assessment is not an end in itself and cannot be divorced from what follows. Accordingly the critical path following assessment should contain a number of elements described as being; care planning; implementation; monitoring and review. Nolan and Caldock (1996) also suggest that the final stage of the assessment process consists of 'agreeing the objectives to be met'. The critical role of goal setting cannot be overestimated,

“These objectives in relation to need are the benchmarks against which all the subsequent stages of care management have to be measured. Objective setting is therefore the key to effective care management” (SSI 1991b para 3.51)

Slade (1994) considers the planning stage as an essential element in bridging the gap between assessment and care management and recommends that the assessment stage of care delivery be kept separate from the planning stage, since planning will involve consideration of local resources,

“By this separation the needs based assessment can inform the planning, and unmet need can be identified. In other words there should be a clear differentiation between the stage of identifying need and the stage of supplying resources to meet these needs. When this distinction is not made, unmet need is often neither recognised nor addressed” (Slade 1994 p295)

There should therefore be clear differentiation between the stage of identifying need and that of supplying resources to meet needs. This requires separation of need from eligibility criteria as determined by

employing professional organisations. Where assessment and planning occur in conjunction there is a predisposition towards bias and away from 'objectivity' Richards (1994). Here the argument is also made that unless the separation between assessment and planning is maintained, the distinction between service led and needs-led assessment will become meaningless. Worth (1998) however describes the difficulties faced by community nurses and social workers in the real world of community care who, in light of resource limitations have great difficulty divorcing assessment from the availability of services.

Three components of assessment have been suggested: analysis of the situation, determination of care needs, and relation of needs to options (Middleton 1994). An awareness of available options and incorporation of this as a consideration in the assessment process may lead to a definition of need in terms of service terminology or eligibility criteria. Such activity would mark a retreat from the needs-led approach expected of assessment and community care provision.

Implementation of care and support in order to meet needs appeared to typify several definitions of assessment. For many interviewees assessment was described as motivated by identifying unmet needs and then meeting those needs. The requirement to reach a conclusion which involved a resource response was often expressed as the main aim of assessment and therefore characterised its definition,

"Assessment is when you are looking to or deciding on the appropriate agency of where to refer the person to, having found an unmet need. That is your assessment: finding need and referring on"  
(N033)

Defining assessment in terms of meeting needs did identify certain stages within the decision-making process which practitioners undertook. The degree to which capacity exists to address needs, the influences which affected the outcome, the focus on types of outcomes and the mechanisms or stages uncovered to get there, and the perceived

requirement to meet need as you identify it, all featured as elements of assessment defined by the meeting of needs. Many interviewees were able to verbalise the stages which led to meeting needs however for others the process became so routine that identification of need and the meeting of need were perceived as one and the same process.

#### **8.1.4 Assessment as a Picture**

The definition of assessment as a picture of a person's needs, issues, situation and environment featured in many responses, however social workers were more likely to use the term 'picture' than their counterparts in health. Defining assessment as a picture allowed respondents to illustrate the important component parts of assessment as they perceived them. For some interviewees, the process of assessment and the components critical to the integrity of their professional assessment reflected an information gathering exercise which resulted in a description of an individual and their situation. Not all interviewees defined this as a list of needs, resource interventions or outcomes: for some the notion of a general picture or overview defined their concept of assessment.

The model of assessment adhered to by interviewees did appear to influence their definition of assessment, with some professionals relating the compilation of an holistic picture as the defining component of assessment. Some interviewees described the emerging picture as that of a jigsaw whose component parts, once assembled, reflected a realistic illustration of the situation at hand.

"Assessment is just an information gathering exercise to let you look at the full picture. It's like a jigsaw: you have to have every bit of the jigsaw to do an appropriate assessment. It's only when you have all the bits that you can actually see if there is a need or a deficit and I can look at what gaps we can fill" (SW020)

Presentation of assessment in a picture format allowed interviewees the opportunity not only to describe needs but to describe situations with

relevant chronology such that needs could be concluded by the reader. In some cases interviewees reported assessment as the picture and did not always explicitly provide a description of need. The perceptual basis of needs identification then allowed readers of the assessment to draw conclusions from the 'pen picture' regarding need, mechanisms to address needs and favourable outcomes.

"Assessment is trying to provide a focussed word picture of an individual's or a family's life situation highlighting the positives, negatives and producing a plan of what is to be done" (SW008)

### **8.1.5 Assessment as Interpreting Information Gathered**

The requirement to gather information to describe a situation and/or identify need, was used by health and social care professionals as their definition of assessment. The ability to collate and interpret information into needs and where appropriate interventions featured as a common definition of assessment during the study.

Interpretation of information gathered was typified by several interviewees by their ability to make sense of multiple pieces of information such as the translation of assessment from an illustrated picture. Collating, validating, expressing information sourced from individuals, observations, written materials, intuition, all led interviewees to define assessment as the interpretation of these elements in a meaningful and purposeful manner.

"It's a judgement at the end of it whether they need assistance to help them function better" (SW005)

Assessment as a process or a cycle of information gathering, interpretation, needs identification, intervention identification, implementation of resources and ultimately review or reassessment appeared to emerge through the course of the study. This was particularly evident when interviewees described assessment as an interpretative and



iterative process during which information was analysed and evaluated. Making sense of the information gathered was described by interviewees as the process whereby the assessment was identified and care or implementation planning began. Information gathering was considered with regard to its purpose and function and in most cases this was to identify and then address needs. Interpretation of information appeared to be aided by the application of a more formalised process which segmented the components of the process from assessment to intervention. In such cases, care planning was often described explicitly as a component of the process.

“Assessment is part of a process where you are engaging with a client initially and collecting information. The assessment is where we are trying to make sense of that information with a view to moving on from that to put in a plan of action, making that a reality as far as possible” (SW010)

Both health and social care staff appeared to share a common understanding of the components of what was accepted as the assessment process. The separation (artificial though it seemed) of assessment, care planning and intervention appeared to reflect the subconscious decision-making activity which occurred simultaneously. The ability to address needs was highlighted as a component of the assessing and planning stage/s when interviewees referred to assessment as the interpretation of information gathered. The collation of information presented professionals and clients with a series of choices about ways of addressing needs which in turn was determined by the resource options available. The ability to address needs based upon interpretation of the information gathered about clients coupled with that already known about resources and their availability led interviewees to describe outcomes as solutions.

In order to effectively problem solve and interpret needs from the information gathered, several interviewees described a corporate approach to assessment whereby needs identification was shared between

client, carer, assessor and assessment contributors. Arrival at conclusions regarding needs and potential ways of meeting them was therefore interpreted as a result of a comprehensive consultation process.

#### **8.1.6 Assessment as a Process**

Assessment was defined by many interviewees as a process in itself as well as being part of a wider process. Assessment often had a clear beginning such as the presentation of a need or a referral to an agency. Few interviewees were able to describe a natural conclusion to assessment: for many it became an ongoing process of reassessment and/or review.

For many older clients, the experience of being 'in need' as defined by an assessment, was described by several interviewees as a journey which was constantly reviewed. The ability to effectively meet needs and 'close cases' particularly with older people experiencing degenerative illnesses, was rarely experienced by those interviewed. In many cases, the identification of need through assessment often uncovered ongoing needs which required regular attention. In many cases this required the exploration of need beyond that which was presented by the client.

Assessment defined as a process frequently alluded to the extensive and comprehensive information gathering exercise which accompanied the process. For an assessment to be acknowledged as a reliable, valid representation of an individual's needs, the extent to which needs were researched and sourced was considered critical,

"I would define assessment as an ongoing process which gives a comprehensive picture of what a person is, who they are, what they think, how they function, how they are coping, if they are not coping: and for that all to come together in the form probably of a report" (SW043)

The ability to understand and perceive situations from the viewpoint of the client and where appropriate the carer was highlighted by several

interviewees such that readers of the assessment report were able to relate to needs and situations as the client would. However when considering the definition of assessment as a process, another aspect emerged which included interaction and involvement of relevant others whose perceptions of clients and their situations helped shape the assessment format.

The assessment process, like other definitions, referred to the requirement to address as well as assess need. Few definitions excluded consideration of mechanisms of addressing needs including those factors known to influence the extent to which assessors were able to address needs. The link between assessing need and addressing need was described as an element in the process of assessing and managing needs. In some cases the role of care planning was separated from that of assessment allowing the assessor the ability to distance the activity of assessing needs from that of addressing them: both of which were subject to identified influences.

As in the previous section, those interviewees who identified distinct categories within the assessment cycle were more likely to distinguish distinct activities such as care planning, implementation and evaluation. Not all professionals however referred directly to evaluation: for many the activity of reviewing care and support, particularly amongst social workers, was more common. Therefore the elements of assessment, care planning, and review featured more frequently as key elements amongst those who regarded assessment as part of a process,

#### **8.1.7 Assessment as a Perception**

Perceptions of assessment have been highlighted throughout this chapter and reflect the particular experience, expertise and knowledge that professionals bring to situations as they undertake and define assessments. For many interviewees, the ability to balance professional with personal perspectives were part of the process. Some assessments appeared to be based mainly upon professional perspectives of need: this

was highlighted mainly with health staff who described the specialist knowledge they brought to particular situations. Despite needs being professionally determined, the emphasis was almost always on gaining insight into the client's perception of need and their resource requirements and preferences.

Interviewees also defined assessment from the perspective and understanding of need as experienced by the client themselves. Some interviewees went to great lengths to examine the personal perspectives of need in order to both understand and attempt to address needs in a manner acceptable to the client. This process began with a professional perspective which was then reflected back to the client for affirmation or rejection.

Rarely was the definition of the assessment of need based upon one type of perception: personal or professional. In most cases there was a compromise between professionally perceived need and personally perceived need. The assessment was therefore a combination of perceptions: which one prevailed appeared to be dependent on perceived risk.

#### **8.1.8 Assessment as Identifying Service Solutions**

The provision of resources as a consequence of assessment has been described in this and other chapters. However during the course of the study some definitions of assessment appeared to centre on the identification of service solutions. Whilst numbers were relatively small per professional group, reference to service solutions was frequently observed amongst social work staff. The rationale for assessment appeared to be defined by some respondents as the identification of resources required. In some cases the processes of gathering information and identifying needs were overshadowed by responses relating directly to resource outcomes.

"You're doing it to see if you can provide things for people" (SW001)

Some interviewees argued that the very nature of assessment: its rationale, process and outcomes as experienced daily by practitioners, encouraged the professional decision-making process to think directly from need to service solution. Since many interviewees described the poor availability of resources, their ability to address needs lay in the provision of a small, identifiable resource pool. Consideration of mechanisms, methods, resources to meet needs outwith that known pool, by virtue of experience, led assessors back to existing resources therefore several interviewees described effective assessment as that which was contained within the confines of realistic interventions. Whilst needs-led assessment processes were recognised in principle to be good practice, the reality experienced by interviewees suggested an inability to meet needs in a needs-led fashion (even if they were identified in a needs-led manner) therefore assessment often became resource-driven. Few interviewees separated the assessment of need from the meeting of need and when asked to define assessment many incorporated an outcome focus,

"Assessment is the process of identifying need, of locating the different responses to that need and ways of meeting the need using resources that are available or looking at resources to meet that need" (N016)

The reality of limited resources and limitless need placed interviewees in a position of compromise. Some interviewees described the dilemma of understanding need on one hand and resource capacity on the other and attempting to balance both in a way that satisfied the needs and preferences of the client and the needs and preferences of the professional and their employing organisation. Many described the process of 'plugging' clients into existing services, suggesting the lack of a perfect fit in terms of service solutions. There was always the expression of the requirement to address to some degree the presenting needs.

“It’s looking at individual’s needs and trying to match those needs with the services available which might not always match their needs” (H002)

In order to deliver services to clients, interviewees described the necessity to match needs with resources regardless of clients’ personal preferences. The prerequisite to identify and respond to need, which was highlighted in almost every definition of assessment, provided valuable insight into the practical application of needs-led assessment and resource-driven intervention. Both appeared inextricably linked within practice, to the degree that some assessors failed to recognise any distinction between stages including assessment, care planning, implementation and review/evaluation. For such reasons assessments themselves were epitomised by service specific language.

In addition to the habitual nature of assessing need and accessing limited resources, professionals identified a lack of trust in recording unmet and unmeetable need. The reason for their suspicion appeared to lie within their own experience of no change in service planning or provision for communities, despite practitioner effort to identify resource gaps. Interviewees regarded this as a personal, professional and organisational failing to individually and corporately respond to needs a factor which impeded needs-led assessments.

## **8.2 Chapter Conclusions**

Defining assessment presented interviewees with the challenge of distilling multiple processes, decisions, influences and motivations into a succinct description. For such reasons the definitions described in this chapter reflect cross cutting components. There was a general sense that assessment was such a common activity that description of its component parts proved an almost impossible task for some interviewees. Many definitions covered a multitude of areas whereas other interviewees took time to identify distinct elements of assessment important to them as professionals.

All elements explored in this chapter appear to describe a process aimed at gathering the appropriate information to facilitate reliable decision-making by professionals and clients regarding both their needs and the interventions required in order to address those needs. Indeed the three main categories frequently cited as defining assessment included: identification of need or problem, information gathering and meeting needs. The extent to which some elements appeared more critical and the processes employed to undertake them varied amongst interviewees, although few discernible differences were identified between professional groups.

The differentiation between assessment and addressing needs was rarely clearly defined therefore the concept of needs-led assessment was tempered with resource-driven influences. The distinction of assessment and outcomes became difficult to disentangle and reflected the difficulties of the daily application of needs-led principles and resource-driven practicalities.

## **CHAPTER NINE**

### **9 FACTORS AFFECTING NEEDS-LED ASSESSMENT**

#### **9.1 Chapter Introduction**

Having considered the factors which define need, assessment and mechanisms of needs identification, the focus of the study concentrated on the extent to which factors influenced the performance of needs-led assessment. Explicitly asking interviewees what factors influenced their assessment of need and their ability to be needs-led, allowed consideration of key elements: some of which were expressed explicitly and others indicated implicitly through responses to vignette-related questions and direct questioning. This chapter aims to consider in detail the factors volunteered by interviewees as influential in their ability to be needs-led with respect to assessment. Like previous chapters the majority of this chapter will concentrate on the four main categories most frequently cited.

#### **9.2 Overview of Responses to Study Questions Eliciting Factors which Influenced Needs-led Assessment**

Following presentation of each vignette, interviewees were asked what factors influenced the extent to which they were able to meet needs. The absence of a separation between needs assessed and needs addressed was notable: for most interviewees the process of identifying needs involved describing mechanisms of meeting or attempting to address those needs,

“It’s difficult talking about needs: you are immediately talking about services” (SW005)

The issue of resources was the most frequently mentioned factor when respondents were asked to reflect on the extent to which needs could be



addressed and for this reason the majority of this chapter will focus on the components of resource implications. This is outlined in Figure 26 alongside the other factors identified as influential. The very nature of the human interaction in both assessing and addressing needs was evident across clients groups therefore this chapter will endeavour to capture the personal conflicts experienced by interviewees in the achievement of needs-led assessment within the confines of organisational constraints. The complexity and connectivity between the assessment and addressing of needs made it difficult for participants and the author to deconstruct components of interlinking attributes. For the most part interviewees appeared comfortable to describe the reality of an aspirational versus a pragmatic approach to needs-led assessment,

“The problem is: I know assessments should be needs-led but a lot of the time they are resource-led because you are working towards a service rather than the other way round” (SW028)

Figure 26 outlines the general factors identified by the author throughout interview analysis and reflects the main areas of influence. No interviewee failed to identify resources as an issue in addressing need: for the majority of respondents this referred to a lack of resources as opposed to a multitude of choice.

Influential Factors Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Resources	42	45	5	11	2
Compliance	33	41	4	8	2
Risk	27	38	3	4	2
Organisational factors	27	40	3	2	1
Organisational values	23	33	1	4	0
Experience	28	27	2	2	1
Communication	23	27	4	4	1

Influential Factors Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Needs Assessment	19	27	1	7	0
Geography	6	7	2	2	0

**Figure 26 General Factors Identified as Influencing the Extent to which Needs could be Addressed**

Whilst similar patterns were observed between professional groups, social workers in the main appeared more consciously aware of influential components: this is not to imply that nurses were unaware, simply that they were less likely to voluntarily verbalise these influences. The subconscious nature of many of these influences should not be ignored: in some cases failure to verbalise might reflect the intrinsic nature of the influences developed over time and with experience.

### 9.2.1 Needs-Led Assessment and the Influence of Resources

The role of resources on the assessment process and means by which needs were addressed cannot be underestimated as Figure 27 identifies. When describing the role of resources, interviewee responses ranged from resource availability, funding and staffing issues to the process by which resources were introduced.

Resource – Influential Factors Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Resource availability	37	44	3	9	2
Waiting lists	21	30	3	4	0
Resource awareness	14	8	3	1	0
Funding	18	30	5	3	0
Alternative options	27	24	5	10	1
Relationship with providers	15	29	2	5	0

Resource – Influential Factors Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Lack of staffing	16	6	3	6	0
Availability of informal care	18	15	2	5	2
Ease of access	18	13	0	0	0
Eligibility criteria	12	12	2	5	0
Minimise intrusion	11	10	1	1	0

**Figure 27 Resources: Factors Identified as Influencing the Extent to which Needs could be Addressed**

The main recurring themes are now considered:

#### **9.2.1.1 Resource Availability**

Resource availability was the main area of influence volunteered by almost every interviewee with social work staff highlighting this slightly more so than health interviewees. Many respondents appeared to accept that resource availability (or unavailability) would affect not only the extent to which needs could be addressed but the manner in which they were assessed,

“I don’t think you should assess for services but at the same time when you are doing the assessment, you are discussing some of the opportunities or avenues that are open to you to resolve things. You have to be aware of the fact that you are working within limitations. There is no use promising someone the moon if it is not going to be there” (SW024)

Awareness of resource availability, although a conscious deterrent to needs-led assessment, was highlighted by many interviewees as an

aspect which had to be considered during the course of an assessment. The rights or wrongs of this were explored by some, but the rationale of assessing needs for many interviewees required knowledge of what resources were or were not available. For most respondents, their presence as an assessor was the result of a referral, suggesting a perceived need, and intervention requirement. The course of embarking upon an assessment without considering the resource implications was considered by some to be negligent.

The result of an awareness of resource availability, for many interviewees, presented the potential to unwittingly undertake a resource-led assessment with the client's best interests in mind. Despite, by virtue of the knowledge of this potential influence, actively resisting being resource-driven, for many interviewees, the opposite became true in practice.

Interviewees were very frank about the role and influence resource availability had upon their assessment of need and the ways in which need was addressed. The reality of operating within resource restrictions could not be ignored by most interviewees who saw it as their responsibility to both assess and address needs. Most interviewees, particularly within social work, made reference to their professional responsibility to undertake needs-led assessments and described their assessment practice in light of this incentive but within the restrictions of finite resource availability.

The predilection towards resource-driven assessments was not always attributable to years of experience of limited resources. For some interviewees, the very models, in which they were trained, included a practice persuasion towards a resource-led assessment as opposed to a needs-led approach. Application of assessment models, however needs-led they appeared to be, seemed to be tempered with resource availability constraints in practice,

“My experience since I left college has been based very much upon the social model that I was trained to use, not the medical model. It’s very much based on what the initial presenting problem is and then an assessment of knowing what’s around. So if I’m not careful then it can become resource-led as opposed to needs-led.” (SW007)

Many interviewees struggled internally with this balancing act where the desire to be needs-led was constrained by externally driven factors such as resource availability. Many recognised that this was an area outwith their control. The belief that policy incentives and perceived good practice were undermined and considered unachievable due to these external constraints was frequently alluded to. The models and values instilled during professional training and practice were described as influencing the approach taken toward needs-led assessment and the impact that resource availability and awareness exerted upon the process. For many interviewees this involved a critique of what was described as medical and social models of care.

Multiple references were made to the medical and social model of care during the study. This was used as a blanket term to describe the differences between the approaches adopted by each professional group. Despite respondents referring to the models, further questioning identified a lack of insight, understanding or thought about the components that constituted a medical or a social model of care and what factors distinguished one model from another.

Nurses often described their model of assessment as based upon a medical perspective: some enhanced this by describing the holistic approach embraced by this model, however many highlighted the specialist, clinical nature of the assessment undertaken,

“Health are very much linked into the medical model and don’t always approach things from a holistic point of view: anything outwith an illness-based problem is not perceived as being able to be solved by them” (N042)

The notion of need and solutions as a component of the medical model was voiced by several housing respondents who described nurses as problem-solving in their 'medical' approach to assessment,

"Health are much more clinical: they look at the medical aspects: 'is there medication we can give somebody, is there something that would solve the problem?' With social care: it's about the support elements they have got" (H003)

Ability to manage needs in a medically therapeutic manner was described by a number of nurses during interviews. There was often recognition that not all needs or problems had medical or social solutions. The sense of professional duty, requirement or responsibility to address needs within a collaborative and multidisciplinary manner was reflected through discussion and many nurses described outcomes in terms of social interventions as well as medical interventions despite perceptions held about them by other professionals, as one social worker suggested,

"Nurses have been trained from the medical model and we (social workers) have been trained using a social model. Social work give the medical model a really hard time because it treats the symptoms: it doesn't look at the person. It should also look at social factors too" (SW029)

The perceived absence of consideration of social factors within a medically based model of assessment was raised by several social work staff, many of whom attributed this to the rigidity of the medical model. There was a general perception held by social work staff that medical-based assessments were subject to strict parameters which in turn restricted the perspective adopted by the assessing professional. Nursing staff interviewed made little reference to perceived limitations of a medical model. Whilst it was accepted that much clinical work was directed by medically-perceived need, the majority of nurses regarded this as a holistic assessment of need incorporating all aspects of daily living. Few comparisons were made by nursing staff about the ability of either health

or social work staff to undertake a holistic assessment based on the model they had been trained in and had most experience of. Several nurses did recognise the perception held by social workers in relation to the medical model and defended their position,

“Nurses rightly or wrongly think they assess better and are more holistic: they have always looked at housing, social issues and we are aware of illness and poverty and have been trained to assess individuals as a whole” (N007)

One component of the medical versus social model theme which emerged during interviews was the perception of roles undertaken by professional staff. Nurses perceived a duality of roles as both assessors and service providers: social workers were described as assessors and care managers. One consequence being that with respect to resources, nursing staff considered themselves a service intervention as well as an assessor, a perception rarely expressed by social work staff.

“I am not just there to assess need; I am there to provide an intervention or a treatment from a nursing perspective. The bottom line is I am a nurse and my training does come into that and the experience I have gathered , but there is not a social worker who could come in and do my role – definitely not” (CPN005)

Nurses recognised they had skills to undertake assessment and care management roles in addition to the provision of clinical interventions however care management was considered the remit of social work. Nurses often described time constraints as the key factor which limited their ability to assess, address and manage care and for this reason were compelled to hand over the care of clients to social work staff who were perceived to have the time and responsibility to care manage. Few nurses welcomed the opportunity (despite their perceived capability) to undertake the role and/or task of care management.

Similarly health professionals' perceptions of social work models of assessments were often based upon the assumption that social needs were solely considered including housing and financial implications. The description of the nature of social needs rarely extended beyond a person's ability to relate socially and interact effectively within their physical and social environment. Whilst questioning the content of the medical and the social model failed to capture much detailed comparison, the process by which assessment was administered, applied or undertaken appeared to encourage some debate. There was general consensus amongst health and social care staff that the model used, provided a framework for data collection which, in the context of resource availability was subject to general, limited interventions. The result for many health and social care practitioners was that despite the model adopted, the process undertaken resulted in similar outcomes.

"Nursing models and social work models have always looked at things in a different way. We (health) always put health first whereas they (social work) would put the social need first. We will probably on a lot of occasions come to the same conclusion but the way we do the assessment is different" (N038)

Social workers described in more detail the specific components of a medical and social model of care including their origins and implications for practice. Many interviewees favoured the social model above the medical model: the social model was defended based upon its citizen-centred approach, its holistic nature, its ability to manage multiple perceptions of need and its dynamic interaction with past, present and future elements of a client's existence. Social work as a profession appeared to identify itself strongly upon the benefits of the social model of care therefore any criticism of this model was met with a strong defence,

"Need is subject to the cultural effects on society and the individual. Social work has always been about that much wider agenda. It recognises these things and tends to first of all stand on the side of



the person. The state is paying you to argue with the state on behalf of the person: it has always been a strange professional background value system but nonetheless that value runs very strong within social work.” (SW018)

The social model did not appear to be restricted to the process by which information was gathered, interpreted and acted upon but appeared to provide a value base upon which professionals interacted with clients, promoting choice through the process of empowerment.

With respect to social work there was concern raised that poor public perception affected successful engagement and outcomes for clients. Social and health care workers described social work as possessing a certain stigma which caused resistance amongst the public to engage their services. Maintaining a professional approach to needs-led assessment and methods of addressing needs, was made more difficult by public (and sometimes professional) opinion of social work,

“A lot of people live in fear of the social work department: it's really quite sad because that's not your job. You are not there to terrify the client. You are there to put them at ease” (SW017)

This was compared to the perceived acceptable status of health services which in contrast seemed more acceptable to clients. Failure to cope as a consequence of ill-health seemed more palatable to clients as was the expectation that health services would assess and address needs. Many reasons were suggested for the perceived difference in public perception of health and social care ranging from concerns over cost to coping skills, factors which were rarely applied to health professionals.

“Older people seem to think of social workers as people prying into their affairs” (N009)

The perception of social work as ‘the welfare’ also appeared to be considered by some interviewees as a reason for client resistance to their

involvement. On the other hand health care, traditionally free at the point of contact, was cited as being more favourable because of this very fact.

Models of care and assessment carried with them professional identity and purpose. Applied within a resource constrained environment, models of assessment proved critical to the extent to which needs or interventions were pursued. The sense of powerlessness that knowledge of resource constraints produced was tangible throughout interviews and will be considered in more detail throughout this chapter. Many interviewees justified their approach based upon components outwith their control. This rationale was recognised across professional groups and was reconciled by some who still recorded needs for which no service could be provided.

Some interviewees made every effort to resist the temptation to assess for outcomes which were achievable, and demonstrated an ability to separate the assessment of need from ways in which need was met. No one professional group appeared to be any more proficient or aggressive in this approach. This approach however was not one undertaken by every interviewee. The recording of assessed needs in many instances was dependent upon the language of resources.

#### **9.2.1.2 Waiting Lists**

In addition to the lack of service availability, many respondents identified delays, mainly in the form of waiting lists. The identification of needs and access to resources, for some interviewees were regarded as stages along a continuum: the timescales between them appeared to play an important part in the identification of need for particular services. The perception that waiting lists were the responsibility of other organisations was frequently raised as areas of frustration. An inability to quantify timescales or even guarantee service provision was a source of particular concern for interviewees who subsequently depended on different professional agencies to meet the needs they had identified. For this

reason many of the discussions relating to waiting lists often led to debate over professional responsibilities.

Waiting lists appeared to be a symptom of difficulties within a system aimed at delivering services. Whilst most of the criticisms regarding delays were levelled at Local Authority provisions (from professionals within and outwith the organisation), the emergence of waiting lists was often attributed to other resource related factors such as limited availability, poor funding, restricted eligibility criteria. Many nursing staff reiterated frustrations at various stages along the continuum, attributing most of these to social work. Social workers were particularly in tune with the extent to which waiting lists determined service provision and expressed frustration equally. The organisational constraints, purposes and values within which health and social work services operated however, led to significant differences of opinion about the acceptability of waiting lists:

“There are some things that can go on waiting lists, but health issues I don't think can” (N001)

#### **9.2.1.3 Resource Awareness**

The requirement to identify a need and refer to limited resources was highlighted by many interviewees; although their level of resource awareness varied, causing concern for some interviewees who described the balance between assessing and addressing need.

For some interviewees, resource availability and awareness allowed them to pick and choose from a variety of sources. Some interviewees, new to particular geographical areas or client groups, bemoaned the fact that their lack of knowledge of local resource availability affected their ability to effectively assess need: so conjoined were the needs identification and service access components of assessment.

“You’ve got to have in your tool bag a whole list of services that you can offer, especially things you can put in right away” (SW021)

For some interviewees resource awareness and availability components preceded the assessment stage: the assumption being that if no reasonable service response could be provided then the rationale for the assessment came into question. Clearly this approach was not endorsed by all interviewees. For many the opposite was true, with the assessment of need preceding any decision-making activity about how certain identified needs ought to be met. Indeed for some assessors the requirement to record meetable and unmetable needs was highlighted alongside the perceptions and preferences of the client and carer.

Separating the client and carers’ preferences from a professional knowledge of resources and their availability was an approach adopted by some of those interviewed, although the difficulty in maintaining a distinction without raising false expectations was often highlighted. For some assessors a lack of resource awareness placed them in an enviable position whereby needs could be identified in isolation and then services sought to meet those particular needs as opposed to the contrary: the latter being the most common experience across professional groups.

Of the interviewees who expressed this sentiment almost all identified the difficulty experienced in applying this in practice. Many exhorted needs-led assessment as the preferred approach however years of experience of lengthy waiting lists and poor service response, encouraged interviewees to assess for resources known to be reliable and readily available. Whilst these might not always meet the needs of the client in the tailored way described above, the knowledge that a response had been made appeared to satisfy needs in both the assessor and the client. Those few assessors who continually strove to assess need regardless of resources and their availability, tended to do so because of personal experiences whereby the benefits of innovative resource responses had been evidenced.

Lack of resource awareness was expressed by some nursing staff who accepted that despite referring to social work on a regular basis, knowledge of their role and ability to meet needs was limited. The value base upon which nursing operated often left nurses with a need to respond in some way.

#### **9.2.1.4 Funding**

Resource awareness was not the only area of potential influence identified by interviewees. Many reflected on the role that funding exerted upon the assessment process. Knowledge of funding issues (mainly restrictions) appeared to suffocate the assessment process as described by many interviewees. Funding was more often cited by social work staff as an influential factor in determining to what extent needs could be addressed. For many, this was due to the fact that most social work services were means tested whilst health services were free at the point of delivery. The effect this had on the professional/client relationship was described as detrimental,

“It’s a very frustrating part of the assessment because you want to carry out a needs-led assessment: you want to provide appropriate support for that individual to maintain as much independence as possible. If you are constrained by finances it is very difficult to do that and to some extent you feel as though you are failing the person” (H001)

Knowledge of the cost implications to other clients and the organisation often caused interviewees to undertake assessments based upon service provision for the greater good. For instance, if a resource known to be limited was identified for a number of clients, then those in greatest need were often identified as requiring that service whilst others were supplied with the most suitable alternatives. The financial differences between the health and social care model in relation to the potential influence that knowledge of funding exerted upon the assessment process was

verbalised by each professional group. Social workers in particular described the tensions experienced in practice,

"This department are a lot to blame. We advertised for years about what's available and now the council are saying 'oh no we don't have the funds'. So it's difficult for people to understand: they've been brainwashed for years that the help is available" (SW013)

Professional perceptions were vocalised moreso in relation to funding than with any other area. For health staff the need to refer onto social work staff in order to access resources identified as a consequence of a health assessment: and for social work staff the need to refer to health staff for investigation and intervention regarding particular health related issues, were frequently raised by interviewees. In the case of health staff there was a perception that the transfer of responsibility was mainly a financially driven one,

"I would be involving social work because they are the money people: they are the ones who hold access to services and they are the ones that make decisions. It is handed over to them because they now have the purse strings" (CPN006)

In the case of social work, the issue of 'holding the purse strings' appeared to be a role which neither enhanced nor reduced their capabilities as assessors. Few social workers relished the role as budget holder. The requirement to rationalise needs against costs and an awareness of limited resources and 'deserving cases', was often reiterated as a significant difference between health and social care services and at times a barrier to effective collaborative working. The perception of the medical model as assessing within medical parameters was frequently vocalised by social work staff and often caused frustration about an expectation to respond regardless of financial constraints. Some social work interviewees however, recognised the potential value of this position in relation to a needs-led approach. The freedom from financial awareness and accountability appeared to release staff to assess need based

primarily on need and not resource or financial implications. This was alluded to in 1986 by Davies and Challis and subsequently (amongst others) Stalker and Campbell (2002).

Health staff frequently expressed concern at the influences financial issues brought to bear upon the provision of resources to meet needs. Most health staff acknowledged that social work staff assumed the responsibility for budgets and therefore resources access, however there was often a perception expressed that this led to gatekeeping of resources based on organisational requirements as opposed to client need. Some expressed sympathy for the unenviable position that involved the assessment of need and financial responsibility for responding to need: others expressed scepticism about the perceived justifiability of failing to assess or respond to needs based upon financial constraints.

"I can be cynical and say that a social worker, addressing needs would put a monetary value on it. I think myself, if I was addressing needs, money would come into it. Social workers are bound by cash whereas we would base assessment on needs: cash would not come into it, 'this is what this person needs therefore this is what this person should get'" (CPN04)

Many statements were made about the behaviours exhibited by experienced assessors. Many reflected a tendency to assess for what could be provided despite paying 'lip service' to the requirement to undertake a needs-led assessment. Knowledge and experience of perpetually overstretched resources and budgets were perceived to facilitate the assessment of what was realistically achievable for individuals. The notion of needs-led assessment was often described as idealistic and unfair to both clients and practitioners who consistently were unable to respond effectively to needs identified. Like any habitual behaviour, knowledge of limited resources and finite finances often confined the assessment of need within those parameters. Whilst this type of behaviour was observed across the study groups, health staff

mainly criticised social work staff for failing to be needs-led in their approach as a result of financial and resource-driven constraints.

Whilst greater direct access to resources was often suggested by health staff, the pressures and subsequent influences that this exerts on assessment and resource response as experienced by social work staff, appeared to be a disincentive to needs-led assessment. Concerns over raising false expectations, operating below what some professionals considered acceptable circumstances, and ultimately a sense of powerlessness to address needs for which resource provision was unavailable or inadequate, were elements identified as undesirable by interviewees. For many social workers the discomfort produced by these factors was lessened by simply assessing and referring to resources known to be both accessible and available.

Funding was considered less of an issue for clients who were able to purchase services for themselves. The choice available to them both in terms of type, response time and frequency of service intervention was in stark contrast to those who depended on statutory provision:

“It appears that if you have the money, it can buy you better services and more choice of services” (SW025)

Given that the majority of interviews were undertaken within deprived areas of Glasgow where there was a high degree of social poverty, few interviewees expanded upon the freedom of choice afforded by financial independence. Most clients known to interviewees were dependent on state benefits; indeed one of the initial actions undertaken by practitioners was to ensure benefit maximisation. The frustration at the inability to respond effectively to needs was not only expressed by health staff but was frequently voiced by social work staff who were disillusioned by the failure of resources to adequately meet those needs identified. This extended beyond meeting the needs of individuals but included the needs of communities on a long-term basis. The public perception, mainly of



social work was considered to be tainted by the perception of an inability to effectively identify and respond to needs.

#### **9.2.1.5 Relationships with Providers and Alternative Options**

Professional identity was identified as important to almost all interviewees. Poor perception of the profession was often equated with poor perception of the professional and influenced the reception given to assessors and subsequently their ability to assess need. A perceived inability to adequately meet needs for individuals and communities or to provide support on a long-term as opposed to short-term basis was believed to compromise trust and credibility between assessor and client: elements already identified as essential in building rapport and establishing effective channels of communication. Interprofessional relationships were also affected by an ability or inability to meet needs. The relationship an assessor had with a service provider was often considered influential to the extent to which professionals could address assessed need. Relationships with service providers were sometimes described as under pressure when services could not be provided or alternatives were used in place of more appropriate interventions.

The need to establish a relationship with service providers based upon a realistic understanding of their roles and responsibilities was highlighted by many interviewees. For some, relationships with service providers were based upon the strength of their negotiating skills, whilst for others it was based upon a personal knowledge of individuals within organisations. The benefits of good working relationships with other professionals and service providers were often highlighted as producing more effective, successful outcomes for professionals and clients alike.

Access to resources was described by health and social work staff alike as overly bureaucratic whereby manoeuvring a client and their carer through the intricacies of the community care world, involved 'good navigational and networking skills' (N020). Often the systems which each organisation

operated were perceived as potential barriers to assessment and resource access. Complaints were made about an inability to reach professionals on the telephone or failure to have telephone calls returned: this was a complaint expressed more so by nursing staff than social work staff. Similarly the process of identifying need, then justifying resource access within health and social care systems was highlighted as a potential inhibitor to meeting needs.

The practical reality and awareness of eligibility was identified by interviewees from each of the professional groups as affecting the extent to which needs could be addressed. The concept of eligibility criteria clearly differed between practitioners with the added difficulties of some interviewees accusing other organisations of adjusting their eligibility criteria to maintain service demand. For some respondents, eligibility criteria related to the processes required in order to progress an assessment of need to access resources: for others it related to a list of criteria set out by organisations to limit the parameters within which a client was considered suitable for a particular service: for others eligibility criteria covered a host of perceived organisational barriers which had to be overcome in order to achieve a desired outcome for a client and/or carer. Several examples were given during the course of interviews, as to what factors constituted eligibility criteria and the inhibiting effects this had on the assessment process. For many assessors the need to match needs to eligibility criteria itself was burdensome,

“Because people don't fit neatly into these little categories” (SW006)

The need for eligibility criteria was recognised by some interviewees as a way of ensuring services were targeted appropriately, however in a climate of poor service availability, the presence of eligibility criteria became a matter of gatekeeping resources.

#### **9.2.1.6 Lack of Staffing**

Knowledge and access awareness (including eligibility criteria) to appropriate practitioners and service providers was constrained by a lack of staffing. Where this was highlighted during interviews, staffing was used to describe those individuals responsible for assessing and providing care, therefore in some instances: lack of staffing was a criticism of the health, housing or social work departments' lack of personnel to manage demand: or it related to the inability of resources to respond due to a lack of manpower or suitably skilled staff. Lack of staffing was identified as a concern by professional groups. For some interviewees it was used as an excuse for failure to meet needs appropriately. The transfer of blame from personal responsibility to organisational accountability was highlighted in the course of interview discussions. Whilst some assessors were critical of other organisations' perceived lack of responsiveness and responsibility, others recognised a common constraint and sympathised.

In some cases knowledge of staffing shortfalls was described as directly affecting the assessment of need. Justification was provided in various forms including the avoidance of raised expectations amongst clients and carers, sharing of caseload demands, self preservation. A perceived inability to deliver the care required, either directly or through another resource provider, for some assessors caused significant degrees of personal distress.

#### **9.2.1.7 Availability of Informal Care**

The role of informal carers in delivering flexible, tailored services to individuals was frequently cited, as was the need to establish the carers' perspective on the needs and resource requirements of any given situation. In the main each of the professional groups interviewed were sensitive to the needs and the contributions of informal carers and sought to address needs as determined by them and the client. An awareness of

the emotional cost of caring was demonstrated by professionals who sought to ensure that the process of assessing and addressing needs included carers: most endeavoured to avoid any perceived exclusion of carer or family contributions to particular needs. It was often highlighted that carers did not consider themselves as carers but referred to themselves as a daughter, son, neighbour, husband, wife therefore assessors were sensitive to the needs of the wider family. As a result many packages of care were described in terms of formal and informal care provision.

Acknowledgement of the role of informal care, prior to contact with health or social services often led to respondents identifying the need to minimise intrusion by gradually introducing the idea of resources and then initiating resource intervention should that be considered necessary. Most assessors were sensitive to the fact that older people and particularly those with dementia often found the prospect of service intervention daunting. Knowledge that resources existed that could improve a client's quality of life and a sense of professional responsibility, often drove assessors to consider a multitude of service interventions. However most refrained from the urge to 'flood them' (SW019), 'overload them' (N017), 'throw a whole load of services at them' (SW007), 'pile too many people into a house' (N040), instead opting for a more gentle introduction of support, paced by the client and carer themselves.

Resource intervention in relation to needs assessment raised many issues for respondents during the study. Assessments were often described and recorded in the form of outcomes which themselves reflected resource requirements. At the same time resource implications as described above influenced the assessment process consciously and subconsciously with assessors struggling to separate the assessment of need from the realities of resource knowledge. The language of needs and resources were often interchangeable in descriptions provided by interviewees, further highlighting the close practical relationship between the assessment of need and the ways in which needs were addressed.

### 9.2.2 Needs-Led Assessment and the Influence of Compliance

Influential Factors Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Client cooperation	32	39	3	7	2
Client preference	31	39	3	4	1
Carer preference	20	38	2	4	2
Carer cooperation	19	37	1	5	2
Client perception	17	23	1	1	0
Assessor's powers of persuasion	13	8	2	4	0
Stigma	5	7	2	2	0
Client demand	1	11	0	0	0
Loss of independence	3	5	2	0	0
Fear of long-term care	2	3	0	1	0
Carer guilt	0	4	0	0	0

**Figure 28 Compliance: Factors Volunteered as Influencing the Extent to which Needs could be Addressed**

The area of client and carer compliance was referred to by the majority of respondents as indicated in Figure 28. The most frequently identified influential factors in relation to compliance, when asked the question 'to what extent are you able to address needs?' were the areas of client cooperation and client preference followed closely by carer preference and cooperation. The extent to which needs were determined and addressed by client and carer perception / demand was evident from the responses given although social work staff did appear to be directed by client and carer requests more so than health staff. Those responses made most frequently are now considered:

#### **9.2.2.1 Client and Carer Preference and Cooperation**

Client cooperation was considered a key influential factor in the assessment and management of needs. The degree to which clients agreed and concurred with professional perceptions of need and resource recommendations varied in practice, however in the main, respondents recognised the requirement to be person-centred in their approach and therefore respect the decision-making activity of the individual being assessed.

The willingness of an individual to accept help was often described as both a driver and an inhibitor to the introduction of formal resources. The assessment process usually incorporated a personal perspective which helped determine the person's desire to receive support. Most assessors recognised that not everyone was keen to have strangers in their homes, undertaking tasks on their behalf, whilst others welcomed with relief, the support available. Similarly the client's right to refuse recommended support was often raised as justification for not responding when clients failed to cooperate. Interviewees often expressed frustration and at times concern when services, known to alleviate strain, were refused; nevertheless the clients' right to self-determination was in the main upheld, however reluctantly by the professional.

The issue of client cooperation was volunteered more frequently by social work than health staff and appeared to be a fundamental component of the model of assessment applied. To ignore a lack of cooperation from clients was regarded as being in contempt of certain professional values,

"Even though we've identified all these problems and potential resources to solve them, they (the clients) may well not want to participate and we can't force it on them. We have to give them the opportunity to make some decisions and be involved in the process"  
(N042)

The ability to accept, and in some cases tolerate the refusal of services seemed difficult for professionals to accept, although their adherence to particular approaches to assessment compelled them to cooperate with the client's wishes. This was an area that many social workers suggested might differ between professional groups.

The need to balance a personal (i.e. client) perspective of need and outcomes, with a professional perspective was discussed in more detail by several interviewees who considered the imperative to be citizen-centred in their approach to needs-led assessment and care management. Most of the detailed discussion regarding this was volunteered by social work staff who appeared to position the client and carer perspective more centrally in the needs assessment process. The notion that some assessments were professionally driven and as a consequence resource intervention was dictated by practitioners was frequently voiced. Social work staff often accused health staff of adopting this type of approach and as a result, minimised the client's perception and choice and maximised their professional perspective on what constituted need and what resources were required.

Many of the experiences recounted supported the notion of the client's ability to choose where they were deemed to have the capacity to do so. Only when perceived risk outweighed capacity to choose did most professionals intervene without the client's cooperation although most identified this as a last resort. Many described skills they had developed over the years to engineer client cooperation. The importance of client choice and preference more often overruled professional perceptions of need and intervention.

"Unless clients really cannot make a decision then their views are the most important. This is their life. I cannot say that they should do this or that. I can suggest that this will help but I cannot force them to do something they don't want even though they may struggle. I feel more like an empathetic facilitator in terms of arranging services for them" (SW027)

The professional ability to accept and tolerate client choice, particularly where risks were identified was raised as an area of concern and one which could determine the difference between adopting a professional perception of need or a personal one. Whilst the two are not mutually exclusively, the responsibility to respond was felt more acutely when professionals determined need and were perceived to dictate resource intervention. Where individuals were enabled to identify and report their perceived needs and preferences, the role of the assessor often changed from that of assessor/intervener to that of assessor/coordinator. The person-centred approach described so emphatically by social work staff often favoured the client preference route despite professional concerns and appeared to be supported within an organisational structure whose shared values recognised the importance and centrality of client choice.

Within the group of nursing staff interviewed similar issues were raised about ensuring client involvement in the assessment process, facilitating client choice and where necessary withholding resource intervention due to client preference. This was fundamental to the principles underpinning their assessment process; nevertheless nurses were more likely to explicitly identify the conflict of perceptions between client and assessor. Despite reflecting on certain actions undertaken to try and support individuals who chose not to access resources, nursing staff also identified the potential for individuals to express a preference which was based upon what they believed the nurse wanted to hear as opposed to how they really felt or what they preferred. The public perception of nursing again was considered a key aspect to the apparent higher levels of compliance amongst clients who were recommended services by health staff as opposed to social work staff. Awareness of the 'power' associated with health professionals was recognised and in some cases used to the assessor's advantage.

Client and carers views were considered in tandem, with only a few assessors identifying a need to separate the assessment of both sets of needs in order to determine recommended outcomes. This was particularly difficult for health and social care professionals alike when



discrepancies emerged between client and carer's perceptions and then additional professional perceptions.

"Constraints could be the relatives: that is a terrible factor if the two opinions conflict or they just don't want to tell the patient the problems. It is like a conspiracy they have got going" (N031)

The need to negotiate carefully the intricacies and sensitivities of client and carer/s preferences with an aim of achieving mutual cooperation created challenges for professionals who made use of all their skills, knowledge and experience to navigate their way around factors which presented real influences on their ability to professionally assess and determine how needs ought to be addressed. This was particularly true when resource constraints influenced the needs-led component of assessment and resource delivery. Resource constraints were as much an issue when considering client and carer compliance as with any other area.

#### **9.2.2.2 Assessors' Powers of Persuasion**

For some interviewees coping mechanisms had been developed which allowed them to distinguish between the dichotomies of perception of need. Often this was based ultimately on a professional distinction between what was perceived as a need and what could be considered a want, and what interventions were achievable given certain circumstances. This was expressed by several interviewees, particularly nurses who had made the mental distinction between needs and wants and then practically applied this to their assessment process.

"The argument I always put to them is 'a need is something you won't survive without, a want you will survive without' and that is my bottom line" (N017)

Most interviewees asserted the client's right to accept or reject support where they were deemed capable of making informed consent although it was recognised that decisions made by clients had implications for carers and family members who may then have to shoulder the burden of caring. Interviewees described their own attempts at persuading clients (and sometimes carers) of their perceived recommendations based upon a knowledge of the ripple effect of non-compliance.

Most interviewees also acknowledged the stigma attached to being in need, requiring support or in receipt of services. The perceived stigma attached to accepting support from statutory services was highlighted by almost every professional group, whose actions subsequently attempted to avert any form of stigmatisation. Professional experience had taught many practitioners that to pursue the issue too aggressively led to further resistance and withdrawal from potential supports,

"One of the big problems of assessing anybody is that if you start to push the issue you want, then you start to come across as an authoritarian figure which immediately leads people to clam up"  
(SW018)

A perceived loss of control and independence was highlighted as a factor which caused clients to retreat from service provision. The need for interviewees to not only be aware of these underlying issues but to possess skills and techniques to divert this association were considered critical components of assessment expertise.

#### **9.2.2.3 Client Demand**

The demands made by clients upon professionals and resources in order to address needs, was an area highlighted by interviewees. Where it was raised as an influence in their ability assess and address needs, there was often evidence presented of particular experiences which caused respondents to be more sensitive to client demands and the subsequent

pressures this placed upon them to act in a way they might not otherwise have chosen.

Some interviewees described heightened client demand as an aspect of class, social status or education. These demands placed certain pressures upon individual practitioners and organisations to respond in a particular way.

“The better their (client’s) education, the more they do demand. In more affluent areas, because of education, they are not so inclined to just accept what you say without questioning until they are satisfied with the answer” (N033)

For some interviewees, the process of being challenged was welcomed and allowed reflection on the assessment process and subsequent outcome. However for the majority of interviewees, demanding clients presented unrealistic expectations and made, what was considered unrealistic requests upon professionals. Within the study group social work staff were more likely to volunteer the influence of client demand upon the assessment and meeting of needs. For some it had a direct influence in their ability (or inability) to be needs-led. The frustrations caused by demanding clients or relatives were expressed by interviewees on two levels: the frustration of direct contact with ‘pushy’ people and also the frustration at the organisation in which they operated which did not always to favour the perception of the professional. In some cases clients benefited from persistent demands, despite assessed need, adherence to policy and protocols, and professional perception.

“It depends on how pushy people are: it’s really a shame because those who shout the loudest get it. Those who don’t tend to get a more resource-led assessment rather than a needs-led assessment” (SW028)

#### **9.2.2.4 Loss of Independence and Fear of Long-term Care**

One component which emerged after detailed analysis of the data, was the perception of long-term care. It was often alluded to by interviewees in relation to various components when considering the factors which influenced the extent to which needs could be addressed. However it was not until all the data analysis was available that the significance of the perception of long-term care was realised by the author.

Long-term care was referred to in some capacity during every interview and was frequently identified when assessors discussed client or carer fears including the loss of independence or inability to cope within their existing environment. Whilst this was not considered unusual in itself, it did provide some comparative information about the professional and public perception of long-term care. The concept of needs-led assessment and the ability to address needs seemed to halt at the mention of long-term care. The extent to which approaches undertaken to ensure needs were identified, resources sourced and accessed, appeared less important once the decision was made that long-term care was required. Perhaps the lack of detail about this resource, which was identified by several assessors, reflected the perception that all needs were expected to be met through the provision of long-term care, therefore the requirement to deconstruct needs, identify interventions and plans of care appeared less necessary. Despite the implications for clients, carers and their families being described as particularly traumatic, the perceived effort to undertake a needs-led assessment of the care required within an institution was never raised during the course of the study. Long-term care, whilst recognised as a last resort, seemed to be an all encompassing method of meeting multiple needs, absolving the assessor of the roles and responsibilities expected of them within the community.

The avoidance of long-term care was often the starting point for many interviewees when considering the needs of the couple depicted in the vignettes. From their experience, interviewees described the process they

would undertake in practice, including the drivers and inhibitors that accompanied the assessment and meeting of needs. For many assessors their initial role was to reassure the client and their carer, reiterating the centrality of the client's position and perceptions within the process.

Many social work interviewees described their role as one of facilitation with the ultimate goal of maintaining independence for as long as possible. Whilst this was a common motivation, it was often counterbalanced by knowledge that the timescale of what was 'reasonably possible' was often determined by factors outwith their control. These included: the declining condition of the client and/or the carer, resource and financial restrictions and a failure to meet organisational expectations of eligibility.

Where community care is perceived as inadequately meeting the needs of individuals and long-term care is considered by professionals as the organisational requirement, and this is resisted by those being assessed then the onus falls upon informal carers to fill the gaps left by limited resource interventions. This can only be maintained in the short-term as described by interviewees. The option of long-term care carried with it significant implications in the assessment of need and the mixture of responses which had to be supported by informal care. Because the consideration of long-term care in itself appeared to herald the end of the road for community care, the effort with which alternatives were pursued appeared to wane, perhaps partly due to the knowledge that community-based resources were only sustainable in the short-term.

Admission to long-term care was considered in light of whose decision it was to identify this as the most appropriate option. During the course of the interviews many perceptions were expressed about how and why people were admitted to care and ultimately whose needs/preferences was this intervention meeting. Whilst the implications for the carer were considered in detail by some professionals, others were criticised for being too quick to jump to the conclusion that complex needs could only be met within institutional care. Many supported this claim with a belief that

some assessors sought to address every need identified and failed to recognise the client's right to self-determination despite the presence of risk, and the carer's choice to continue caring regardless of motivation (e.g. guilt) or capacity to do so. A professional belief that not every need could or should be met was frequently challenged during the interviews.

"The district nurse is more likely to go in and say 'this person needs residential care' but it's maybe not looked at in greater detail. I would say that their approach is more service-led than ours would be" (SW014)

In many cases admission to long-term care occurred as the result of a crisis. Some assessors deliberately avoided pushing the issue with clients, knowing that at some stage a crisis would emerge thereby removing choice. Whilst this was recognised as a less than favourable approach, it was the practical experience of many of those interviewed. Voluntary admission to care appeared rare amongst the professional groups interviewed: the emphasis being on maintaining clients and their carers in the community for as long as possible.

Long-term care and a perceived loss of independence marked an important transition in a client's life, as described by interviewees. It also marked a significant stage in relation to how needs were identified and addressed. The influences which complicated the needs-led process appeared less troublesome when institutional care became the only feasible option. Perceptions of institutionalisation held by professionals, clients and carers often made the transition from community to long-term care a more difficult one. Assessors often had to draw upon their own interpersonal skills and those of colleagues and carers in order to support the transfer of care from community to institutionally based services.

One of the noticeable observations made by the author with respect to this transfer, was the withdrawal from needs related language to that of generalised care provided in a controlled environment. Needs appeared to be highlighted mostly when the client was community-based and had the

capacity to express preferences or dislikes. Client choice and person-centeredness seemed to subside as the person's condition deteriorated. The carer's needs became more important and resource intervention appeared to be aimed at meeting the carer's needs mainly in alleviating carer burden as opposed to addressing the specific needs of the client. The extent to which this observation was generalisable could not be explored within the course of the study given that the vignette sequence was limited by time and scope. The extent to which decisions would be made and interventions undertaken in the absence of an informal carer would prove a useful comparative exercise which would help identify the extent to which carers' presence, perceptions and needs prolong or accelerate progress towards long-term care.

### 9.2.3 Needs-Led Assessment and the Influence of Risk

The concept of risk was often discussed in relation to the type of care provided to clients, particularly whether this ought to be community or institutionally based. For some interviewees, the decision between the two options was based entirely upon their perception of risk and safety.

Influential Factors Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Safety	16	19	1	3	2
Priority	15	13	4	1	0
Risk to self	6	20	0	2	0
Risk to others	5	15	1	2	1
Ability to cope	7	12	0	1	1
Problem significance	11	8	0	0	0
Fear of litigation	6	6	1	1	1
Choice	0	6	0	0	0

**Figure 29 Risk: Factors Volunteered as Influencing the Extent to which Needs could be Addressed**

Figure 29 outlines the number of responses given when interviewees were asked to describe the factors that influence their ability to address needs. Risk was highlighted on several occasions however professional perspectives varied somewhat. In general social work staff outlined the risks and considered the consequences in more detail than health staff who tended to consider more general areas such as safety, priority and problem significance.

Consideration of risk was often coloured by the pressures exerted upon interviewees to assess and respond in a particular way. The extent to which perceived excessive risk existed directed the assessment activity of professionals either toward or away from long-term care and appeared for many professionals to be the determining factor.

There was often a debate vocalised by health and social work staff about the threshold between needs and risks. The merits of fostering independence were described against concerns over tolerable levels of risk. Thresholds of risk appeared to differ between health and social work as described by those interviewed,

“Health workers will tend to eradicate risk whereas we (social workers) tend to allow a huge amount of risk relative to the need and that comes from the person's rights perspective - they've got their right to refuse help” (SW018)

This was a concept frequently contested by nurses. Where risk appeared to exceed a certain level, the client's right to refuse was disregarded and needs were responded to. Some nurses attributed the difference to the medical versus the social model of care whilst others identified this as a pragmatic mechanism by social work to manage demand and supply. Risk management when described from a social work perspective was often a test of the integrity of the social model of care which firmly placed the client and their wishes at the centre of the assessment process, sometimes at the expense of professional perspectives. Many social workers described personal concerns about this and the way they were



supported organisationally to accept risk taking: each justified by the person-centred nature of this approach.

The meeting of two professional approaches to assessment which in their own unique way claim person-centredness did lead to practical issues when implemented. Health staff, due to financial and resource access restrictions were required to refer to social work for resource intervention whose perception of risk and priority did not always correspond.

#### **9.2.3.1 Safety**

Safety was the main area cited with reference to risk and was highlighted by health and social care professionals alike. Safety was used by practitioners to cover a myriad of actual or potential areas of risk. For many, tolerance of safety was based upon their professional perception of the client's capacity to make an informed decision to remain at home with or without additional resource. Almost every professional, despite their own professional concerns, acknowledged the client's right to self-determination.

Accepting the client's right (and capacity) to choose the level of risk they were prepared to live with, was described as a complex choice but a necessary aspect of health and social care in the community. Risk management versus risk aversion was often discussed however the implications of attempting to eliminate risk not only removed client choice but left few professional options other than twenty-four hour supervised care. Living with risk and questionable safety was identified as a component part of any assessor's job. The need to identify, quantify if possible, and ultimately manage safety risks was considered part of the role of any health or social care worker. The extent to which this component was tolerated and managed by professionals differed, often due to organisational demands or professional experience.

The detailed identification of risk and safety concerns was discussed by several interviewees who described the use of recording tools to assess components such as risk, capacity, and safety. For some, this produced a safety net; for others it appeared artificial because of the intricate relationship between risks and need,

“I don't like individual standalone risk assessments. I think it should be inherent in every assessment and it should be woven through it. If you are doing your assessment right in the first place you will have identified risk and you will have qualified it throughout including the care plan and how you are addressing it” (SW035)

Professional perspectives in relation to safety and risks were identified throughout the interviews and suggested several safety concerns in relation to the vignette sequence. The balance of risk-taking activity, assessment activity and interventions was often identified as intertwined therefore needs were rarely described or addressed without due consideration to safety and risk. Some organisational structures and protocols were described to support the consideration and response to safety and risk related issues particularly within social work (Stalker 2003). Waterson (1999) highlighted the motivating effects that risk perception exerted upon needs-led assessment for social work staff, suggesting that assessment related activity was aimed more at managing risk than need.

#### **9.2.3.2 Prioritisation, Problem Significance and Ability to Cope**

There was general consensus that the degree of priority with respect to risk had an influence on the extent to which assessors could address needs. Sometimes interviewees expressed concern or alternatively a sense of support where prioritisation was imposed by organisations. This seemed to happen more so within social work which operated a prioritisation scale, than it did in health care where prioritisation seemed to occur at practitioner level and was determined by the professional's

perception of the degree to which a person or situation ought to be a priority. The latter approach prioritised clients on two levels: prioritisation of the needs identified and urgency of response to each need for an individual and: prioritisation of the client's needs above that of others. This was often tempered with consideration to client choice. The issue of individual prioritisation was often described as having knock-on effects on other clients.

Professional and organisational restrictions were often blamed for the requirement for prioritisation systems as well as the apparent 'unfairness' such systems engineered. Professional differences in perception as to what constituted a professionally determined or an organisationally determined priority were frequently voiced. The views expressed by nursing staff in relation to social work's prioritisation of individuals' needs were identified as a key difference between the two organisations.

"Sometimes when you come across a problem and you think 'this needs to be sorted', they (social work) don't see the urgency that we see. There is the difference of priorities between the two departments." (N022)

The demands faced by social work services were often referred to as justification for having a prioritisation system in place. The effect that organisationally determined priorities placed upon individual practitioners was evidenced through many comments made during interviews. Prioritisation appeared to be made at the point of referral, based upon presenting needs.

Prioritisation within social work did appear to be more standardised than in health services. Prioritisation categories were in place across the Local Authority employees within the sample group ranging from Priority 1 to Priority 4: Priority 1 representing those considered in greatest need (these were described as life and limb cases), and priority 4 referred mainly to quality of life issues. Prioritisation was often undertaken by senior members of the social work team which determined the speed at

which client's would be allocated a social worker and therefore have an assessment undertaken.

Subsequent to an assessment, prioritisation categories appeared to be utilised again to consider how appropriate it would be to provide the resources recommended as a result of the assessment: again this decision was often made by senior members of the social work team. Whilst this was common practice within Local Authorities, its effectiveness and justification were contested by several interviewees.

The unpredictable nature of risk was frequently used to describe the need for a longer-term perspective on prioritisation. Whilst a system of prioritisation supported an organisation and its professionals, it was not always considered to be in the best interests of the clients it served. Similarly a lack of standardisation regarding prioritisation was considered by some interviewees as creating professional vulnerability.

#### **9.2.3.3 Risk to Self and Risk to Others**

Categorisation of risk was identified during several interviews however this was more evident amongst social work staff and CPNs. In general, risks were considered as either risks to self or risks to others. Whilst risk to self was cited slightly more frequently, there was a marked difference between social work responses to these two areas compared to nursing responses. Nurses rarely identified risks specifically such as mentioning categories of risk: instead risk was used by nurses as a broad brush term to cover all aspects of risk. Responsibility to identify and respond to serious risks however was considered by some respondents as everyone's responsibility,

"I don't think that is an individual decision: it has to be a collective decision. If we are talking about serious self harm risk or risk to others in the community, then I don't think any one discipline should take responsibility for that" (SW024)

In some instances the requirement for organisations and professionals to assume responsibility for risk management in the case of what was considered serious risk was highlighted as were the experiences of some high risk scenarios. Often the combination of risk to self and others as a result of a variety of potential factors, led to the compromise or abdication from previously upheld organisational values. This was more often articulated by Local Authority staff,

“Even though you have different bits of social work theory and other theory you always work of a basis of your social work values. One of the basics is respecting people’s wishes, unless of course there comes a point where the risk to their health or safety supersedes that” (SW029)

Those employed in housing expressed a similar sentiment and regarded risks around health and safety as overriding personal and professional values and client choice and self-determination. Perception of problem significance and ability to cope were also identified by interviewees as considerations in the extent to which needs could be addressed. Perception of how significant a need was often led to actions which were aimed at lessening the significance and/or increasing the client or carer’s ability to cope. The limitations experienced by professionals in persuading clients, accessing and delivering support such as preventative care, were often cited. For many interviewees their experience was that resource intervention was more likely to happen at the point of crisis. This was echoed by some social work staff whose experience of resource release and response was based upon the significance of the problem in question. The more urgent the problem, the more likely a resource response became.

“Resources are a restriction but when it gets urgent the resources are more likely to be coming more quickly because the need is greater” (SW033)

The requirement to be honest and realistic with clients was highlighted where risks existed and actions were considered necessary in order to help them cope. The significance of the problem/s experienced, created particularly sensitive discussions which were described as testing the assessor's communication skills, especially when they (the professionals) considered themselves powerless to guarantee resource interventions.

The obvious frustration about being accountable yet lacking the power to directly access or authorise resources was clear across professional groups however social work described themselves as having a more intimate knowledge of the likelihood of resources being mobilised particularly in the instance of a crisis. It appeared that social work resource requests at the point of crisis were more likely to be acted upon. For such reasons social workers were more definitive with clients about the likely outcome of the assessment process. The need to manage risk appeared to lead to the abandonment of some of the principles of needs-led assessment. The requirement to ensure safety, balance choice against risk, support client and carer sometimes left assessors little choice but to professionally intervene and deal with the consequences once the risk was removed or reduced. The professional motivation to act appeared to be based upon multiple factors, not least the personal and professional fear of being held accountable for the realisation of a recorded risk.

#### **9.2.3.4 Fear of Litigation**

The fear of litigation was explicitly raised by several interviewees from health and social care: often references to legal implications were interspersed throughout discussions. For this reason, although it was not highly rated (with respect to the frequency with which it was raised), the subtle references alluding to an underlying professional fear of accountability (if not litigation), justified more detailed consideration of this potentially strong motivating factor by nursing staff.

“Need must be met in some way because there is a legal responsibility, a certain loyal responsibility, and an ethical responsibility. We are all very aware of the legal situation nowadays” (N017)

To limit risk related fear to that of litigation appeared short-sighted. Of those interviewed, many described the practitioner/client relationship not only in therapeutic terms but also in caring terms. The nature of this relationship created strong links professionally, morally, ethically and at times personally with clients and carers. The perception that something must be done in relation to need was highlighted by social work staff too, although the organisational restrictions placed upon them often led them to be more conservative about the needs identified and methods of addressing them.

“They are supposed to be needs-led assessments but there is no doubt that resources or lack of resources does have an influence in what you say at the end. Other fears such as legal reasons or not wanting to raise peoples’ expectations, cause you to hold back on what you tell the client” (SW005)

Whether attempting to protect the client, carer or the professional, the motivation to be guarded in raising expectations without the ability to ensure needs will be met, was expressed by many interviewees. The pressures experienced and described in avoiding unrealistic expectations or not bowing to the demands of relatives, were based on an assumption that assessors were professionally accountable.

The need to identify and respond appropriately to needs in the midst of risk, posed particular concerns for staff around legal and professional accountability. There was general criticism of health staff’s lack of recorded information. One nurse described the rationale for being discreet with written material,

“We don't record as much because there is a fear of writing things in black and white, because you are liable for what you have written”  
(N010)

The legal status of written information regarding the needs and care of individuals appeared to be a deterrent from recording reliable and accurate information. The implications for information sharing such as that required to access resources were rarely discussed: simply the protection of professional status. Few interviewees who expressed this sentiment were able to support it with knowledge of legislation.

For some staff, motivation to be needs-led in their assessment was affected by the perceived legal and moral implications of identifying needs for which no resource could be provided. Social workers in particular were sceptical: several citing their experience of completing care plans (CC4), which outlined unmet and unmetable needs, which to their knowledge were never utilised to aggregate, understand or address the needs of communities.

The protection of the organisation as well as the clients were elements raised by several interviews. Disillusionment with some organisational processes highlighted not only the poor public perception of organisations such as social work but also raised the concerns staff expressed with their own organisations. The support and trust of the professional body to which individual practitioners were registered were elements considered critical to the effective fulfilment of a role that aimed to identify and address needs of clients in a way that ensured their best interests were paramount.

#### **9.2.3.5 Client Choice**

The issue of choice was raised explicitly by a minority of social workers within the study sample. It was an area often inferred during all interview discussions although social workers appeared to be the only professionals



who explicitly explored the role and influence of choice in relation to risk as a potential influencing aspect to the assessment of need. Often the rights of the client to choose or refuse resource intervention were used to demonstrate the importance with which client choice was exercised and acted upon. This was always balanced with a professional perspective of risk: where clients were considered able to make informed decisions, no matter how poor those decisions appeared to be, the need to sustain the client's choice and right to self-determination was upheld. This was reflected in work undertaken by Myers and MacDonald (1996) which highlighted the balance between client choice, professional perception and risk.

Risks associated with choice were mentioned most frequently in relation to the subject of domestic risks including the need to move house to supported accommodation or long-term care. The element of choice exerted by clients and carers was perceived by social workers as a calculated choice based upon personal and professional standards. The need to reduce risk whilst upholding the client's right to choose was debated.

Ensuring client cooperation in reducing risk where it was identified was described as a test of an assessor's communication and persuasive skills. The benefits of being perceived in a positive, non threatening light was highlighted by several interviewees as was the need to ensure the client understands and consents to interventions being made. The fear of litigation was rarely far away when staff discussed the issue of client consent.

The perception held by many of the social work staff interviewed was that nursing staff adhered to a different level of risk tolerance than social work. The apparent ease with which social workers as professions and social work as an organisation appeared to respond to risk and uphold client choice was perceived in stark contrast to health professionals whose actions at times appeared to be directed by the need to reduce or avert risk at both an individual and a corporate level. The client's ability and

right to choose were often cited by nursing staff as important components of the assessment process, however when risks were identified an inverse relationship appeared to develop between client choice and risk, in the process of addressing needs.

“Health workers tend to eradicate risk whereas we tend to allow a huge amount of risk relative to it. They (health) are driven by an equipment-based world where there's an Elastoplast based elimination of risk” (SW018)

Not every member of social work articulated this sentiment as strongly but there was an underlying presumption that health staff were less tolerant of risk than social work. In cases of risk as perceived by health staff, there was the assumption that the client's choice was forfeited by the professional's opinion of what was required to address needs. Miller (1976) used the term 'basic needs' to describe the level at which needs should be met in full. The basis for this was the 'avoidance of harm'. This proposed a standard at which a threshold should be set, though Lightfoot (1995) describes differences in the conceptualisation of 'avoidance of harm' statements. The balance of client and professionally perceived need, preference and risk would appear to influence the level at which that threshold is set and suggests it is customisable between clients and organisations. The professional's ability to sustain a client-centred approach, which through necessity, often involved the balancing of ever changing needs and risks, was highlighted in the study as an area whereby organisational support was critical. This meant the corporate adherence to organisational values as well as the professional and personal support to make and live with 'risky' decisions.

#### **9.2.4 Needs-Led Assessment and the Influence of Organisational Factors**

Throughout the study references were made about professional organisations. These were sometimes referred to as 'bodies' and appeared to represent the qualities manifested by many interviewees. As a

consequence the notion of an organisational culture was raised, components of which were demonstrated, either consciously or subconsciously, by professionals.

Organisational aspects, when considering the factors which influenced the extent to which needs were addressed, are included in Figure 30. For many interviewees the components listed exerted negative pressures upon them although some aspects such as peer support and supervision were described as positive influences.

Influential Factors Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Assessor time	21	21	1	1	1
Assessor peer support	4	34	0	2	0
Supervision	1	16	1	0	0
Pressure from others	5	11	0	0	0
Caseload demands	0	9	0	0	0
Bureaucracy	3	3	0	0	0
Staff morale	4	0	0	0	0
Poor management	0	4	0	0	0

**Figure 30 Organisational Factors Volunteered as Influencing the Extent to which Needs could be Addressed**

The notion of solidarity within an organisational body was voiced more explicitly and more frequently by social work than health staff. Peer or supervisory support was described more frequently by social work staff than health staff although the benefits of these were acknowledged by nursing staff. Similarly the underlying professional / organisational motivations for undertaking particular courses of action (or inaction) emerged during interviews: these will be discussed briefly prior to consideration of the practical factors categorised in Figure 30.

Health staff were described by non-health professions as being more judgmental in decision-making. This related to professionally defined need which appeared to dominate health assessments. The judgemental or non-judgemental model adopted to define need became a distinguishing factor between health and social work services. The medical model was frequently referred to as judgemental whilst the social work model was considered non-judgemental.

The making of judgements about need, regardless of a professional aversion to the concept, appeared to occur during almost every interview when respondents were forced to gather and interpret information, identify needs and consider potential outcomes or resource interventions. Decision-making was a key component at every stage however the opportunity to colour that process by value laden judgements was a risk identified by professionals with social work staff accusing health staff of frequently falling into this trap. Professions appeared to be defined by their value base therefore any compromise served to highlight perceived professional differences,

“Social work staff generally come with different values and principles and that is how they are trained: they tend to stand back more and write down and observe what that person needs and wants whereas health staff are looking at it from the point of view that this person has this illness, so these are the difficulties that are going to come from that: they are a bit more prescriptive” (SW030)

Professional training and perceived roles and responsibilities appeared to affect the value base adopted and practiced by assessors. In the case of social work the value system underpinning practice was regarded highly by most social work staff interviewed and many expressed explicit knowledge and awareness of the role of this value system upon their daily practice. Nursing staff did not reflect the role of health-related values to the extent that social work did despite similarities between the organisations with respect to processes, aims and objectives. Of those health professionals interviewed the majority referred to models of

assessment as opposed to values: the decision-making processes involved in every assessment were described with little or no reference to the values of judgements upon which decisions were made. This is not to say health lack an underpinning value base but did suggest that professional alignment to an organisationally identifiable value set was less explicit within health as a professional group.

The overall approach to need, based upon a myriad of principles, concepts and values, referred to generally as the medical and the social model of care, appeared to distinguish the two main groups included in the study. Their perceptions of themselves and each other were often peppered with contradictions but the overarching theme appeared to be the perception of the value-base upon which medical and social models of care were constructed and operated,

“The medical model is very black and white. If someone has a heart attack you take them in, you deal with them. From a social work point of view we have to look at much wider factors including what is risk and what is acceptable risk, and what is the client’s right to take those risks” (SW019)

Social work perspectives of social models did acknowledge the need to include all components which could potentially lead to need including health needs. Many social workers identified an inability to divorce one model from another. The social model of care was generally considered to be all encompassing (by social work staff) and had the capacity and requirement to incorporate the appropriate components of need identified using a variety of other models including the medical model. The role of the social model was therefore not only in the collection of needs related information but also the interpretation and inclusion of all factors impacting on a person’s ability to live life as they chose. The reality therefore for many practitioners was a model which accepted the conclusions of other models based upon different values, judgements and decision-making processes. The lack of shared values or models created a

requirement for assessors to collaborate, corroborate, and where necessary compromise.

“There are parts of the social life and parts of the medical life and in the middle there is a sort of a grey area which is common to both: that grey area may become less grey the more we work together” (SW036)

A frequently occurring theme was the concept that health staff were considered specialists within the field of clinical assessment and treatment and that their role and contribution to assessment was of a defined, limited and specialist nature. This was a view expressed by many health and social work staff who regarded the contribution of health staff to needs assessment as very specific, prescriptive and limited. Like most opinions expressed this was both supported and contested by professionals from each group represented,

“We (nurses) are lucky because we can look at situations and see what all the needs are and usually the medically and nursing-orientated ones can be solved to a certain extent. Whereas a social worker has to consider the bigger picture and they are not looking at such detail but are looking at an overall picture” (N040)

#### **9.2.4.1 Assessor Time**

The most frequently identified area of influence in relation to organisational factors was that of assessor time. Often, this referred to lack of time to undertake assessments and organise the support required. Time appeared to be a valuable commodity for both health and social care staff and was frequently described in terms of currency e.g. the value added to an assessment and its outcome by the time taken to undertake it, the time afforded by organisations to allow assessors to address needs. Despite general agreement that time was a factor influential in the extent to which needs could be addressed, the professional perception of what

constituted a reasonable timeframe within which to carry out an assessment and respond to needs varied enormously amongst those interviewed. Unsurprisingly GPs (a recognised minority within the study sample) identified the shortest time intervals, within which assessments were undertaken,

“I do it in seven and half-minute intervals all day long and that's quite enough for me” (GP002)

Nursing staff acknowledged that completion of a needs assessment during a busy prearranged schedule was unrealistic and unfair to clients; however the typical time allocated to this activity remained low in comparison to social work staff.

“My assessments are so much better if I have more time: I tend to not do first visits in the mornings but will try and keep it for the afternoon so I can sit down for an hour or more with somebody” (N012)

Time restrictions identified by social workers mainly involved longer periods of time over which an assessment was completed as opposed to the actual allocation of time within a working day. Social workers were quick to identify the time differences between health and social care staff however many explained this in terms of the depth of assessment expected of social workers. No nursing staff expressed this sentiment.

Flexibility with time and delivery of assessment, and where appropriate agreed outcomes and interventions, was not always identified by social workers as a positive factor. For some social workers the timeframe within which an assessment was expected to be completed was considered unrealistic and inhibiting.

Timescales within social work were often determined by the organisation whereas nursing staff frequently referred to the autonomy they experienced in managing caseloads and prioritising care. Many references

were made by health staff, to respond immediately when new referrals were made. Social workers mainly described the process of relationship building with the client, exploring their needs by involving their extended family and ensuring that information gathering was as comprehensive as possible, creating a pen picture of the individual and the factors identified as important to them. Nurses described the elements of communication and information sharing; however it appeared that the time available professionally to devote to these aspects appeared significantly less. Social workers frequently reiterated the need to build rapport and reflect on assessment material to produce an accurate, reliable, valid assessment of need: some complained that organisational timeframes imposed upon this process created significant constraints on the integrity of their professional assessment.

The perception that professionals were 'fire fighting' or 'responding to crises' was identified frequently by health and social work staff alike. Professional activity appeared to be more reactive than proactive: a factor that was described by many interviewees as going against the grain in terms of their training and professional experience and expertise.

#### **9.2.4.2 Assessor Peer Support and Supervision**

Peer support was acknowledged by interviewees as an aspect influential to the ability of professionals to address needs. The opportunities provided by professional peer support were also highlighted by many assessors. These aspects included: sharing experience and expertise, provision of emotional support, the ability to debate and discuss decision-making. The opportunities to share concerns with colleagues in the safety of a professional office environment not only provided the practitioner with emotional relief but also facilitated a joint dialogue between professionals with varying experiences. The wealth of information this brought to situations was welcomed by many interviewees.



Whilst this was mainly happening within organisations, interviewees identified the benefits of extending this opportunity across professional groups. The value in combining health and social care skills, knowledge, experience, expertise within a client-centred, working environment was highlighted by several interviewees.

“The ideal would be for us all to come together and work jointly to fill in all the gaps with regards to any of the individuals that we are caring for in the community. Before we do that though, we need to forge good relationships with each other: we need to trust each other and not be frightened that we are not in competition and not getting our roles confused. Then we can be highly effective” (N028)

Supervision was described by social workers as the process whereby regular meetings with their Senior Social Worker were convened to consider aspects such as the assessor’s current caseload, review and reflect on decisions made and yet to be made, and to discuss future allocation of new cases. Supervision was welcomed by most social workers as a mechanism of formally establishing reflective practice and providing professional support during difficult decision-making. Often during supervision, assessors would be challenged regarding the decisions they made and this process, many described, helped them to rationalise their own decision-making processes and internal mechanisms of prioritisation. The process of supervision was described as a component of social work services and not health services which operated different governance arrangements. The experience of undergoing supervision appeared to have an effect on social workers which caused them to consider challenges positively and to welcome the opportunity to reflect on decisions made, whether good or bad. Supervision, however challenging, was rarely described by social workers in negative or threatening terms,

“I don't mind getting constructive criticism. It's quite good to find out if you are doing the job correctly and it's useful to get some feedback” (SW017)

The requirement to have an established relationship with your line manager was considered as important as the relationship which was nurtured with clients, given the vulnerable position that effective supervision had the potential to place practitioners in. The ability and trust required to allow another professional, particularly one in a position of authority, to interrogate your work did lead to some interviewees saving certain pieces of information for peer discussion as opposed to supervision. The nature of the relationship between practitioner and supervisor was described as generally therapeutic although some social work interviewees did recount concerns.

“You're not really looking at the moral and ethical dilemmas or the pressures that you're under in terms of having to make decisions about peoples' lives.” (SW002)

Supervision, through the course of the interviews, remained the domain of social work and proved to be the arena where social work practice was scrutinised and interrogated in order to strengthen and support it. The degree to which supervision was successful appeared to depend heavily on the relationship and trust between practitioner and supervisor. Where there was perceived to be a strong bond, supervision operated effectively: where key elements were lacking, supervision failed to support the practice of needs-led assessment and management of need.

#### **9.2.4.3 Pressure from Others and Caseload Demands**

One particular area that required professional support was where pressure from other sources drove practitioners in a particular direction. In some cases outcomes were determined by the level of pressure exerted from others including professionals, carers and family members. As one nurse described, her concern about failing to ensure that client's needs were met when she was no longer responsible, led her to pressurise other professionals to respond in a way that allayed her fears of failure,

"Sometimes the more pressure we put on a situation, sadly, the more results we get. I have this phenomenal fear of a patient falling between two stools. I think all professionals have that. I have done the needs assessment but then some people simply pass on and act as though they have washed their hands of it. I see that happening and it worries me" (N017)

Pressure was not always exerted from external sources. Interviewees recognised the internal pressures which caused them to act in a particular manner. For example, the pressures exerted on professionals as a result of demanding caseloads caused certain practitioners to consider multiple factors before deciding on a course of action. Frequently the additional pressures exerted upon and experienced by professionals resulted in service outcomes which the practitioner might not otherwise have identified as a requirement. The example was often given of clients, carers or family members who were particularly articulate and who made representations to senior members of staff in order to secure resource interventions.

In addition to pressures exerted by others, interviewees described ways in which they had to contend with pressures as a result of caseload demands. Not all practitioners could control the number of clients they were responsible for, nor could they control the unpredictable nature with which situations escalated from relative quiet to crisis. The need therefore to ensure that professional time was spread evenly in relation to need was raised by several interviewees: social workers appeared to be the main professional group within the study to highlight the issues of competing caseload demands. This is not to say that the same issue was not experienced by other professional groups, simply that it was not raised explicitly as an element responsible for determining the extent to which professionals could address needs.

#### **9.2.4.4      Bureaucracy, Management and Morale**

Bureaucracy was identified by a small amount of health and social care staff as an influence on the extent to which they were able to address needs. This was often described with references to levels of bureaucracy and red tape which existed within and between organisations. The ease with which resources should or could be accessed following a professional assessment appeared constrained by administrative requirements at various levels,

“It’s a maze and unfortunately it’s not a phone call away: it’s a fax or a story. But the barriers are there to communication” (N026)

An inability to effectively and directly communicate with other agencies or service providers on behalf of clients often caused tensions between organisations. Bureaucracy was described as slowing things down and delaying interventions, in some cases, as urgent. The bureaucracy expected to operate within large organisations such as social work or the health service was acknowledged by interviewees, however when the effects of this were experienced at client level, concerns were raised as to the efficacy of systems. Professionals described practice as subject to restrictions imposed by bureaucratic organisations as opposed to the freedom to operate professionally and autonomously, applying their own professional experience and expertise.

Sharing with clients the constraints of the process appeared, in some cases to help interviewees relieve themselves of some of the burden of the professional responsibility to assess and deliver care. The constant awareness that resource access was the decision of someone other than the assessor, often led to a sense of powerlessness which appeared to be relieved somewhat when the knowledge of this powerlessness was shared with clients and their carers.

Few interviewees (all from social work) identified poor management as a component which influenced their ability to address needs. Of the many social workers interviewed, a key component of their post was the interaction with clients: in some cases this was considered constrained by the restrictions placed upon them by overly bureaucratic organisations. The ability to deliver needs-led assessment as directed by legislation and a sense of good practice and basic human rights, was perceived as being at odds with an organisation which gatekept services, imposed eligibility criteria, screened referrals for urgency of assessment and intervention.

“For me there is the dilemma between what the department says and how we do an assessment: the two are not always compatible”  
(SW035)

There was a general complaint that there were too many managers and not enough frontline staff to deal with the demands of a needy population.

### **9.2.5 Needs-Led Assessment and the Influence of Organisational Values**

Reference to organisational values was interwoven throughout interviews. Some assessors felt a strong sense of belonging and professional protectionism within organisations which made the adoption of the organisation’s values an insidious and often subconscious process. Others appeared unaware of a sense of organisational values but often made reference to particular beliefs which were those of the organisation and not necessarily those of the individual professional. From the interviews several components were identified under the umbrella of organisational values and these are listed in Figure 31 as they were volunteered by interviewees.

Influential Factors Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Record unmet needs	16	18	1	1	0
Lack of control	16	9	0	4	1
Keep person at home	11	15	0	1	0
Avoid long-term care	1	9	1	3	0
Moral & ethical	3	10	0	0	0
Duty to meet needs	9	3	0	0	0
Justify service provision	3	5	0	2	0
Minimise service intervention	4	1	0	2	0
Prevention versus cure	3	2	1	0	0
Crisis response	4	2	0	0	0
Avoid hospitalisation	0	0	1	3	0

**Figure 31 Organisational Values: Factors Volunteered as Influencing the Extent to which Needs could be Addressed**

Whilst some of the categories listed might appear duplicitous e.g. 'Keep person at home' and 'Avoid long-term care', the author considered it important to highlight motivating factors as they were verbally presented by interviewees. Therefore the potentially positive organisational view of providing support in order to keep someone at home is considered alongside the potentially negative view of avoiding admission to care: the outcome is the same in both cases however the perception of the motivating factor was recorded in order to consider whether this had any effect on the process of keeping someone at home and/or out of institutional care. The main areas are now described:

#### **9.2.5.1 Record Unmet Needs**

The principle and activity of recording unmet needs was frequently discussed by interviewees: many asserting the professional, organisational, moral and ethical requirements to do so. The recording of

unmet needs was described within the limitations of organisational, professional, client or carer aspects. Health and social work staff appeared to be in general agreement that unmet needs should be identified and recorded despite the internal and external pressures that this created. As one CPN described, the principle behind recording unmet needs was simple and uncompromised,

“It’s needs-led. If a need is identified then it becomes a need even if we can or cannot meet it” (CPN01)

The perceived professional requirement to identify and record needs that could be met and those that could not was highlighted by several interviewees across professional groups. Many interviewees made little distinction between the identification of unmet or unmettable needs and the recording of those needs. For most interviewees, the recording of need was perceived to reliably reflect what was identified during the assessment process. A sense of professional integrity was associated with the recording of unmet needs and the interaction with clients and carers about an inability to fully meet all the needs identified.

The ability of assessment tools to record unmet needs appeared to encourage this activity whereas a lack of written opportunities on assessment related paperwork was perceived as a deterrent to recording unmet needs. Where the question was specifically asked, interviewees appeared more comfortable recording unmet needs: where there was no natural space on written documentation to record unmet needs the professional response was determined by the sense of importance attached to recording unmet needs.

“If you identify gaps you have a responsibility to address those gaps in the services you provide for those needs even if you identify a need that isn't available, you have to record that and flag it up: you have to chase it up. You have a responsibility to identify to managers if there are gaps. If that is not done, then we are failing our duty as assessors and have been playing with the system. Unless managers

have proper, constructive information then there will continue to be needs" (SW040)

Most social work staff described the paperwork used for assessment which was divided into separate sections and forms. The recording of unmet need appeared to be facilitated by the separation or explicit requests made on different components of the assessment related paperwork. A working knowledge of the process of data collection and apparent lack of collation identified a sense of disillusionment with the religious recording of unmet needs. The perseverance of social work interviewees to record unmet needs with this knowledge, appeared unfaltering, while other professionals identified alternative routes through which unmet needs could be addressed at an individual and then ultimately community level.

Whilst many social workers described the perceived importance and requirement to record unmet need (due perhaps to the fact that those who volunteered to participate in the study might already feel strongly about the subject), others presented a different perspective. Often there was the recognition of recording unmet needs however the actual reality about how frequently this occurred on social work documentation was described by one social worker,

"There is a space at the bottom of our documentation for recording unmet needs. Now social workers were never good at recording that because I worked at Headquarters for a time and we used to see these CC4s coming in regularly and I was lucky if I saw one where the bottom box was completed. So we didn't recognise the unmet needs" (SW036)

The implications for professionals and subsequently clients, carers and communities of failing to report unmet needs were debated by interviewees who felt let down by their organisation and in turn felt they were letting clients down. Some interviewees persevered recording unmet needs whilst others considered the exercise pointless and assessments



became reflective of resources that could be provided i.e. needs identified reflected service provision.

“I would just record what I could meet” (SW032)

For nursing staff, documentation was referred to less frequently as supportive or unsupportive of recording unmet needs. The majority of unmet needs appeared to be recorded out of a sense of professional responsibility. Like many other professionals, nursing staff raised the issue of sharing this information with clients and the potential effects this might have, although not all perceived this as a deterrent to the practice.

The explanation of why an unmet need was identified and recorded was often described as shared with clients, carers and other professionals. In some cases other professionals were perceived to be the cause of the unmet need due to failure to respond appropriately. Nurses expressed this sentiment more frequently as they tended to refer onto other services that had the power and authority to access resources. In the same way, social workers who identified needs and resources, which required the authorisation of their line manager, expressed a similar sentiment.

Not all interviewees shared the belief that unmet needs should be recorded. Some expressed the perception that due to the changing nature of community care, the motivation to record unmet needs had waned and organisational components did not support the practice. Differences were identified between the ‘freedom’ of health services and ‘means testing’ of social services. Some interviewees expressed the belief that health staff, because they were not restricted by factors such as budgets, limited resources, and eligibility criteria were more likely to assess and overestimate the resource requirement. Their expectations as health professionals appeared to be higher than those of social work staff which were frequently described as more realistic. Not all nurses contested this view and indeed some reflected on the poor incentives provided to identify resource intervention when this could neither be guaranteed nor accessed directly,

"I've never been encouraged to record unmet needs before. And in fact one could say that one's job has actually been to stop demands on services rather than encourage them" (N021)

Some nurses identified their role as empowering clients to repossess lost skills through a process of therapeutic rehabilitation. The role of AHPs was described in terms of supporting a patient from a state of dependency toward one of independence. Nevertheless, as was often reiterated during interviews, the client and carer depicted in the vignette sequence were ageing and suffering from degenerative illnesses which would inevitably result in needs. The inability of professionals or organisations to fully meet needs was an area that concerned interviewees, although many identified the necessity to inform clients of the identification, recording and attempts to meet needs in light of an holistic approach which included identification of unmeetable needs.

Openness and honesty were frequently cited as important components of the assessment process particularly when needs could not be met. Most interviewees described alternative ways they would seek to address needs when the preferred service was not available to them: rarely, it appeared were clients left with no service at all. Whilst this was commonly referred to, the disappointment experienced by clients was always a concern. Most clients appeared to respect the honesty with which they were treated and acknowledged the need to identify all needs and respond as appropriately as resource restrictions would allow. Balancing the identification of unmet need was a value upheld by all professional groups, despite the issues it raised for practitioners, clients and carers. The balance of being honest with the assessment, honest with the client and honest with the organisation were all highlighted to some degree, however the need to maintain professional integrity and evidence need in order to support future resource development was used as a counterbalance to the potential detrimental elements of identifying and recording unmeetable needs.

#### **9.2.5.2 Lack of Control**

Whilst exploring other aspects of values considered important to organisations and professionals, a perceived lack of control was identified by several interviewees, particularly nursing staff with respect to access to resources. The effort involved in attempting to undertake and record a needs-led assessment which included the explicit identification of unmet needs was considerable. The identification of needs for which resource intervention was outwith the control of the assessor, led to frustration and disillusionment amongst interviewees. Similarly the restrictions experienced by organisations tasked with resource response were acknowledged by assessing professionals, however the conflict that emerged as a consequence of a perceived failure to act upon a professional's assessment of need was considered to have an adverse effect on the professional relationships in the multidisciplinary community within which all professionals had to operate. The role of professionals was perceived by some to be undermined by the inability to access resources on the basis of their professional assessment.

Nursing staff in particular expressed a sense of powerlessness and directed most of their frustration at social work services. Whilst the reasons for resource restrictions were understood, nursing staff questioned the rationale for reassessing to access resources. The separation between needs identification and resource access, as identified by nursing staff was generally regarded negatively. The acknowledgement and authority attached to a nurse's assessment and resource recommendations appeared to be in question, the opportunity to influence or justify resource intervention appeared to be lacking, and the relationship that nurses then experienced with their clients was often tainted by the perceived lack of power or ability to deliver what was required.

Others identified the process that clients had to undergo following referral to other agencies such as social work in order to access resources.

Nursing staff identified the perceived barriers to meeting needs as a consequence of organisational issues and described the advocacy role they often had to adopt to ensure that clients' needs remained a priority. Social workers however expressed similar restrictions in relation to the referrals they received from other agencies such as health services as well as those clients allocated to them as a result of direct referral to the social work department. Organisationally, restrictions existed which interfered with the assessor's autonomy and meant that in the same way nurses adopted an advocacy role, so too did many social work staff, as access to certain resources were outwith their professional control. Social work as an organisation was described as having to manage the needs of many; therefore the finite resources available to them were necessarily spread across those perceived to be in greatest need or those who had languished on waiting lists the longest.

The levels of bureaucracy identified within the social work organisation during the course of the study were a source of complaint for health and social work staff alike. Many social workers adhered to the clients' right to self-determination however client choice was often diluted by lack of opportunity or priority. Professionals frequently expressed concern at the lack of autonomy and authority in to directly access resource.

"Since I've came into this post I have had to go to other people to access resources. I do the assessment but I'm tapping into other people to provide the resource. And they would make another assessment to see whether that person needed the things I thought were required" (SW009)

Matters were further complicated when organisational values included the rights of carers and family members as key contributors to the assessment process. The degree to which carers' perspectives and needs were included and/or influenced the assessment of the client was frequently discussed: interviewees were sensitive to the fact that carers' choices did not always reflect the clients', and that pressure to respond in a particular manner maybe exerted by the carer and not the client. The

professional balance between carers' and clients' needs then impacted upon the organisational values of listening, respecting, responding to carers needs.

Perceived organisational barriers appeared to have a negative impact on professionals adhering to organisational values particularly around the client and carer's choice of resource intervention. The separation of roles and responsibilities appeared to some professionals to be artificial and unnecessary impediments to achieving successful outcomes following assessments. This was evident in the separation between assessor of need and accessor of resources. For some interviewees, the struggle to maintain professional integrity amidst evolving organisational values raised concern,

"I wouldn't be able to fully meet the needs because I am referring them to other services and it is for them to manage: my hands are tied" (N030)

The effort required to ensure appropriate resource interventions following professional assessment/s did appear to influence the extent to which assessors could meet needs or the lengths to which they would go to in order to address needs.

#### **9.2.5.3 Keep the Person at Home and Avoid Long-term Care**

Another perceived organisational value often expressed by interviewees was the need to keep clients within their own homes. This belief was described with no sense of deliberation regarding needs and community resources, but appeared to be an underlying principle adopted by health and social care workers. The need to keep or maintain someone within their own home was often described in positive terms with reference to the benefits of avoidance of removal of someone from a familiar environment to one which might prove safer but less familiar and therefore, by assumption, less desirable. The realities of maintaining

people at home, despite the underlying principles seemed to be dependent on the course of least resistance for professionals. Health and social work respondents agreed with a basic assumption that clients and carers would prefer to remain at home, perhaps due to experience of similar situations. This was the starting position for many professionals, and interventions were considered from this perspective or with the maintenance of this situation as the goal. Interventions required in order to successfully maintain someone at home were considered by interviewees to vary from one client and set of circumstances to another. The potential interventions which could achieve this goal were dependent on many factors including: carer and client perception, professional experience, organisational factors

Whilst there was general consensus of opinion that interventions should be in accordance with need, some references were made about the professionals' proficiency in determining the appropriate time to abandon community care as a viable option and begin moving toward long-term care. This appeared to be based upon the general perception of need and risk.

"I think we (health services) are quicker to realise the needs for specialised care or when somebody needs long-term care than social work. Personally I think they (social work) will try and tend to keep them in their own home for as long as possible" (CPN003)

More nursing staff made this explicit observation than social work staff although references were made by social work staff that due to their knowledge of community resources, ability to access care, and an awareness of the cost implications and restrictions of access to long-term care, community care was the preferred place within which to deliver care. Long-term care was usually considered only when community care was perceived to fail and was generally a last resort. It was described as being dependent on many organisational as well as experiential factors, therefore the extent to which it could be the product of organisationally inferred values as opposed to personal or professional is an area which

could be explored further. Some interviewees suggest that the organisational climate had changed over time and affected their views about long-term care therefore for some experienced professionals; community versus institutional care appeared to be implied through political and organisationally inferred values.

Other social workers were more blunt about the motivating factors behind community care, suggesting that the goals of organisations were not always within the client's best interest,

"Remembering what the policy of the council now is that person would remain at home for as long as possible" (SW026)

Similarly the motivation to adopt an organisational requirement was discussed in more detail by other interviewees who considered the scenario in light of policy objectives. This added further questions about whether the move toward community care and away from long-term care was a result of an organisational value or a national perspective on best value. Few professionals disagreed with the incentive to keep people at home and out of institutional care and many endorsed this apparent change in thinking, however the realities and pressures of the factors influencing the extent to which assessors could achieve this were persistently highlighted bringing into question the reality of implementing the fundamental principles of community care.

Most interviewees responded to the preference of avoidance of long-term care by positively promoting the maintenance of the person within their own home as outlined above. Of those professionals who referred more to the avoidance of institutional care as an influence, the majority were social workers, although some CPNs did allude to the necessity of keeping people out of hospital for fear of institutionalisation. Where nursing staff made reference to long-term care, hospitalisation was often included whereas social workers almost always referred to long-term care as care provided with a nursing or residential home. As a last resort, long-term care appeared to represent a failure of community care as opposed to a

natural progression or escalation of needs. For some interviewees this was interpreted as failure on their part to adequately address the needs of the client and their carer/s.

Several interviewees described the personal difficulties experienced when care (usually institutional) was provided which had a profound effect on clients and carers. Despite the professionally perceived necessity of providing such care, there was often a sense of guilt or regret by practitioners that they had contributed to a major, life changing event for clients from which they (the clients and carers) might not have the ability to recover from,

"You feel bad: you think 'God because I've been the one who identified needs, she was admitted to hospital and then she doesn't come home'. It leaves you thinking 'God I've been the instigator of that', so you've got to try and deal with those thoughts and feelings" (N034).

Admission to care was not always considered a mechanism of meeting needs, more so a method of managing risk. Needs still existed in care, though they were different from the initial presenting needs. For several interviewees there was knowledge that the transfer of a client from community to long-term care, meant the transfer of one set of needs for another.

#### **9.2.5.4 Moral and Ethical Concerns and Duty to Meet Needs**

Reconciling needs with the intervention of long-term care did appear to place interviewees under pressure and many found this a difficult but necessary component of their role. Similarly the professional and personal requirement to respond to needs was described as a source of potential stress for assessors. The discussion using terms such as needs, interventions, issues was highlighted by some to be very clinical and failed to describe appropriately the personal distress experienced by clients and carers. This was an issue raised not only in relation to the



study but to real life situations where complex human interactions had to be described, rationalised and justified. The professional management of human distress whilst assessing and addressing needs was highlighted by interviewees as the cause of some professional casualties within caring professions. Personal capacity to cope with the demands of health and social care concerns were described as carrying an emotional price tag which not all professionals could afford. This was perceived to be heightened by the knowledge that assessors were expected to identify unmet needs and somehow reconcile that with themselves, the clients and the carers.

“There’s an emotional price because if I identify as a nurse that there’s an unmet need there and there isn’t that service, there is a price to be paid for that because you will start to feel that you are not doing a good job. Your motivation will start to go, your self esteem will start to go, you will start to feel a failure because you can’t provide that person with what they need” (N010)

The need to prevent the disillusionment expressed above was highlighted by several interviewees who described mechanisms of ensuring unmet needs were identified, but that alternatives were sought in the meantime. This was often described not only as a professional, but also a moral responsibility. The perseverance of respondents was evident throughout interviews, but this placed a longer term responsibility on professionals who referred for services which operated lengthy waiting lists. The implications for organisations could not be underestimated given the resources spent on personnel maintaining clients on caseloads until such times as services were delivered.

“As a health visitor or anybody it will remain on your conscience until you have finished that job” (N0020)

The frequency with which moral and ethical values were quoted in relation to how and when needs were responded to, led some assessors to consider the nature of individuals who entered ‘caring’ professions. Some

interviewees suggested there was no stereotypical personality types more inclined to enter caring professions, however for others, caring professions offered individuals the opportunity to exercise the ability to deliver care and support. Some interviewees also discussed perceived, potential differences in the value systems and personality types of professionals within either health or social work. The extent to which these 'values' existed prior to entering a profession, or were instilled whilst employed as a professional was debated,

"Health are coming from a purely NHS philosophy and principle of free at the point of delivery whereas social work tends to go for liberty and people have got their rights. So although people talk about this culture there are fundamental differences about the people who work for social work and the people who work for health: and what their pictures are and what they believe should happen"  
(N010)

In general, differences were described by professionals with respect to the business processes operated by each profession. These were sometimes perceived to create professional culture, and values which determined the assessment and actions of professionals within different organisations. A sense of responsibility to meet needs appeared to extend beyond what was considered professionally sufficient and caused professionals to search in order to achieve an acceptable outcome or interim solution if the preferred outcome was considered unavailable. The sense of duty to meet needs was highlighted by some interviewees (mainly nurses) as a compelling force which caused them to consider every option available. The influence that the outcome had on the assessment was described almost as a cause and effect.

The requirement for the outcome to fit the need was related by some interviewees to the nature of their professional role. The activity and process of identifying needs appeared to be undertaken by most with a view to addressing those needs therefore the implications of restricted outcomes became an issue. Added to this was the nature of caring professionals whose role was perceived to be 'caring' which was

frequently interpreted as meeting needs as opposed to leaving people in need.

The requirement to respond was separated into the professionals' perceived duty to respond and the requirement to respond in order to address identified needs. The two may lead to the same outcome for clients and carers but the motivating factors and therefore influences were different. The extent to which the duty to respond could be described as an organisational value was supported by the fact that many professionals discussed this component with reference to particular organisational requirements and personally perceived responsibilities.

#### **9.2.5.5 Justify Service Provision**

Having made an assessment of need and identified resources, many interviewees described organisational requirements to then justify service provision. In many cases interviewees carefully tailored the language used on the recorded assessment form to facilitate justification of a particular intervention: others used their powers of negotiation and persuasion to make a case that clients should be provided with the recommended resource. These decisions and actions were made in the knowledge that the provision of a service to one client often resulted in the denial of that same service to another client.

"You can make a case but everyone is a priority. My negotiation skills are now excellent because you have to argue why your case should be of a higher priority" (CPN001)

Justification of service provision was categorised by the author as a component of organisational values since decisions were often described as value laden by interviewees or value driven by organisations. The practice of systematically prioritising clients as they were referred to organisations was one area where professionals felt that values and judgements could impinge on decision-making,

“When I am allocating, you do make some kind of causative judgement about deserving cases. I think we do discriminate between clients” (SW005)

The reality of coordinating or delivering services for an infinite and unpredictable number of clients within the constraints of finite resources appeared to create the need to justify resource allocation pre and post assessment. The speed with which assessments were completed was often determined by the priority the client was allocated. This then reflected on the extent to which resources would be released in order to meet that individual’s needs. Interviewees, having identified, quantified and qualified the needs then found themselves with the onerous task of having to justify the prioritisation of one client above another. One nurse described the culture of evidence-based needs,

“The patients’ need it? Prove it” (N010)

Resource related decisions appeared to be made by organisations based upon their perception of the greater good. Interviewees often cited this knowledge and used it to their advantage when making a case on behalf of clients. Ensuring good, trusting, working relationships between professions was also discussed as essential to ensure appropriate resource allocation. Some interviewees acknowledged the need to sacrifice certain good working relationships in order to ensure their clients received the level of service they considered appropriate.

Professionals often used combative terms when describing how they would justify resources particularly on behalf of clients. There was often a sense of competition for limited resources and a notion that all the best skills to ensure a good outcome were not dependent necessarily on good assessment skills but on the ability to stand your ground and make a watertight case to ensure resources were directed to clients. Naturally most assessors had their own client’s needs in mind,

“That is one of our jobs: to fight for people and to fight for resources and services” (SW021)

The bureaucracies associated with ‘fighting’ for resources indicated a hierarchical approach adopted within certain areas whereby ‘rights of access’ were awarded to more senior members of staff. The processes required by members of staff in order to secure funding or access resources could potentially be viewed as a barrier by assessors however most simply described the processes as commonplace. The effort with which services were fought for was influenced by a multitude of factors, and the success or failure with which services were accessed was determined by a multitude of factors. The fairness of the system was questioned by several interviewees who perceived the potential to disadvantage clients with inexperienced professionals, poor service awareness, lack negotiating skills and an inability to reflect on paper and in person the gravity of the client’s needs.

Interviewees were often faced with a professional dilemma where several clients on their caseload required the same limited resource: in such cases personal and professional decisions were made about deserving cases or degrees of risk or urgency. Direct access to resources or funding was not always regarded as the answer to some of the dilemmas faced by professionals: indeed extension of resource access might heighten the need to justify resource provision.

The dilemma between an awareness of needs and an awareness of resources appeared to place professionals in an unwelcome predicament. For some interviewees, knowledge of scarce resource allocation led to a referral overestimating the resource requirement, expecting a reduced allocation but which still meets the needs of the client. For other interviewees an understanding of the ways in which resources are allocated between ‘deserving cases’ caused professionals to withhold referrals for certain clients in favour of securing resources for other ‘more needy’ clients.

Interviewees expressed differences between health and social work staff regarding justification of service provision: social work seemed to possess a more detailed knowledge of how resources and funding were allocated and the effects this had on other clients in need of those resources. Meanwhile most assessors shared the basic organisational value that resources should be justified on the basis of assessed need and should be introduced at a rate which satisfied the needs of clients and carers.

#### **9.2.5.6 Minimise Service Intervention**

The extent to which resources affect an assessor's ability to address needs has been considered in many contexts including organisational values. Resource access appears to affect the assessment process and the way in which needs are addressed. Until now it has been identified mainly in relation to a lack of resources or restrictions placed upon a professional's ability to directly access resources. The converse was raised by several interviewees who identified issues relating to the access of excessive resources for certain clients. Whether this was because access was easier, the client was more demanding, or the assessor was more concerned about the needs of an individual: resource overload was identified as a negative component of care.

"To recommend lots of services might just add more chaos. You don't want to add to the cycle of stress" (CPN006)

The notion of resource overload in the lives of clients and their carers, particularly if dementia was a factor, was cited as a mechanism to reduce the stress of the professional responsible to address the needs, in light of their awareness of potential risks to the client and carer. However resource overload in many instances served to add to the concern, confusion and chaos experienced by clients and carers.

#### **9.2.5.7 Prevention versus Cure and Crisis Response**

A preventive approach to resource intervention was identified by several respondents from various professions. The concern was often expressed that resources were only sought in reaction to a crisis, and given the previously expressed difficulties in securing and mobilising resources, the success of this approach was considered inappropriate. The reality of crisis response and emergency placement in respite or permanent care was a familiar reality for some interviewees who endeavoured to avoid this outcome at all costs. Respondents identified professional differences in the way in which health and social work staff approached addressing needs.

“Nurses think about things more from a preventative point of view”  
(N004)

Preventing or pre-empting the outcome caused assessors to undertake a particular course of action which was ultimately aimed at avoiding long-term care. The ability of assessors to directly respond to or access the type of support deemed necessary, was considered a key determinant of how successful an outcome would be. Because of the differences in access to resources, as described in earlier sections of this and other chapters, social work was considered the deliverer of support and as a result was frequently blamed for the lack of timely intervention. In many cases interviewees from each professional group identified the difficulties experienced by social work in not only assessing, but responding appropriately to needs identified. They were criticised as being reactive as opposed to preventative, as interventions often occurred in response to crises and not as a proactive response to prevent crises emerging.

The consequences of transferring responsibility and awaiting service intervention were perceived by some interviewees as a wait for crisis intervention. Not all professionals were critical of this response: many understood and respected the client's right to choose and refuse

resources and, for many professionals this meant waiting until the client or carer could no longer cope or had the capacity to choose, before resources could be initiated.

Difficult though this was for practitioners, the clients' right to self-determination often meant that professional perceptions of needs and interventions were withheld in light of client perceived needs and interventions. This did not mean that nothing happened in between: on the contrary many interviewees worked hard to persuade clients and carers to accept support.

Crisis intervention was a concept well known to both health and social care professionals. The benefits were at times discussed in relation to the absolute need for clients to accept support and resources: in many cases restraints were set aside at the point of crisis. The fact did remain, and was highlighted by interviewees that come the inevitable point of crisis, resources remained as restricted, and the ability to mobilise them quickly was not always achievable. Therefore successful as it was, and despite how often it occurred, crisis intervention as a mechanism of ensuring resources reached clients in need was rarely the favoured route of professionals. The ability and capacity to act in advance and anticipation of predictable needs were identified by interviewees as the approach of choice.

#### **9.2.6 Needs-Led Assessment and the Influence of Experience**

As was the case when identifying components critical to the identification of need, experience also appeared as an element which was considered influential to the extent to which needs could be addressed. Figure 32 outlines the components identified during discussions about the role and influence experience was perceived to exert.



Influential Factors Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Similar scenarios	22	25	2	2	0
Expertise	14	22	0	0	0
Assessment skills	9	9	0	1	0
Education	7	5	0	0	0
Intuition	4	4	1	0	0

**Figure 32 Experience: Factors Volunteered as Influencing the Extent to which Needs could be Addressed**

There was general consensus between professional groups about the main components of experience and their impact on the assessment. Interviewees described experience with multiple references to the above components so it was difficult for the author to specifically attribute discreet pieces of interview information to one component of experience. For this reason there is some overlap between areas identified. Most interviewees referred to experience as a combination of learned behaviour and underlying knowledge. Experience caused interviewees to act in particular ways and in some cases, participants referred to experience as conscious and subconscious.

The multitude of factors which culminate in an experienced practitioner were considered by interviewees during the study. This was achieved with a degree of difficulty for most respondents who considered their experience an invisible yet tangible component to the complex process of needs assessment.

“I think it’s quite difficult for social workers to attach theory onto their practice because a lot of the time we do it because we just do. You forget the theory, you forget about why you do that” (SW029)

#### **9.2.6.1 Similar Scenario**

The notion of dispensing with theory and progressing with experience was commonly described. Reference made to similar scenarios was the most commonly identified component of experiential factors identified as influential in addressing needs. Knowledge and experience of similar scenarios caused interviewees to act in a particular way, using their experience of the past to predict the likelihood of similar events occurring in the future. Clients and carers were more likely to be assessed and have their needs addressed in a standardised manner given the perceived predictability of certain circumstances, conditions and client groups. Nurses more so than social work staff, described the application of experience of similar situations to current scenarios.

The impact past experiences exerted upon current responses, meant that for some interviewees, their experience of similar situations posed a strong influence over the likelihood and types of decisions made when confronted with new but familiar circumstances. The opportunity to be innovative as well as needs-led in the approach to assessment and resource access, was often redirected to an approach which was driven by past experiences and outcomes. Whilst a needs-led approach was described by most interviewees, assessment related activity appeared to be influenced by experiential elements which were so interlinked to the activities of assessing and addressing needs that it was difficult for assessors to disentangle them. At best interviewees were able to acknowledge the presence of experiential influences within the complex assessment process.

For health professionals, knowledge of disease processes provided further insight into the likely prognosis for sufferers and carer/s. Similarly for all professionals, experience of treating and caring for people at varying stages of a progressive illness presented insight into the potential difficulties which might lie ahead. This often led to predictions being made on the part of interviewees about outcomes and expectations.

The experience provided by knowledge of similar scenarios was often described as helpful for practitioners with respect to directing their actions and helping them predict future stages, thus being able to pre-empt potential crises or at least support carers as they encountered these stages for the first time. Few assessors considered this type of experience negatively or identified the potential to be unidirectional in their approach.

“You're understanding a bit more about the pressures that they (carers) are under. You can then begin to predict things happening”  
(SW002)

For some interviewees the ability to refer on or access resources as and when needs presented, was described as an area of reassurance when dealing with clients with progressive illnesses. In such cases knowledge from similar scenarios about service availability and suitability seemed to better equip assessors to deal with presenting issues. Often this was in relation to the organisational factors and bureaucracies attached to identifying, accessing and allocating appropriate resources.

Certain interviewees considered knowledge of resources and how to access them as skills which not only equipped them in fulfilling the role of assessor but also made them better assessors. This was linked to expectations from clients, carers, referrers, organisations that assessments would result in some form of resource provision. However when a professional's experience of attempting to access resources in a similar scenario resulted in a poor outcome then this appeared to effect the type of activity undertaken when faced with a similar situation. Some professionals were deterred from accessing what they considered suitable resources due to poor previous experiences.

The perceived ability to not only identify resource interventions but to guarantee their delivery appeared an important component of the assessment and subsequent activity. Experience of an inability to deliver resources as promised, deterred professionals from either making recommendations or guarantees to the client, or in some cases, being

explicit about the interventions considered appropriate to meet particular needs. Experience of similar scenarios, it would appear, had taught assessors to be prudent with any assurances. Interviewees were more careful and cautious about what information was imparted to clients and carers in the way of resource reassurances. However experience was also considered to better equip assessors to endeavour to deliver more realistic, achievable outcomes. Experience of similar scenarios was not only limited to professional experiences but spanned personal experiences and those related by colleagues. Through the course of interviews, the more extensive the breadth of experience, the more effective the assessment and outcomes were considered to be.

#### **9.2.6.2 Expertise and Assessment Skills**

Experience alone was rarely used to describe the mechanisms by which assessment and assessment related activity were influenced. Interviewees often alluded to professional expertise which appeared to be a combination of honed assessment skills and breadth of experience. Expertise was rarely defined on its own during the course of the study but was often reflected in responses to the factors which influenced the extent to which assessors were able to address needs. Expertise appeared to be an amalgamation of all things considered good in the art of assessment and was often attributed to those perceived to be particularly proficient at assessment.

Expertise was used to describe everyday actions and activities associated with assessment, without necessarily drawing attention to the expert nature by which some of these skills were exercised. For such reasons expertise was difficult to evidence yet apparent through a skilled, experienced, measured approach to assessment. The degree to which expertise influenced experience (or vice versa) was considered by several interviewees although it became evident that expertise could not sufficiently be described without reference to experience and likewise experience was rarely described without reference to expertise. Where

experience was considered a positive influence on needs assessment, it was often aligned with expertise. Never far from these discussions was the role and influence that assessment skills contributed to the assessment process.

Assessment skills developed by professionals were recounted during interviews and ranged from knowledge of disease processes to experience of needs encountered as a result of illness or infirmity. Assessment skills were used to distinguish professionals as generalists or experts within their field. Whilst it was acknowledged by many interviewees that assessment skills were a taught component of professional training, the honing of these skills occurred as assessors became more experienced in the arena of assessment.

Assessment skills were identified uniformly across professional groups as key contributors to the factors that influence the assessor's ability to address needs. Despite this, the perception of what constituted good assessment skills varied from one interviewee to another and in some cases varied within professionals as time progressed and experience evolved.

Knowledge of the limitations of assessment skills led assessors to consider other components in more detail such as the contribution that other professionals could make to an assessment, or the contribution of the client and carer/s. Acknowledgement that successful assessment was not based solely on assessment skills, was described by some assessors who were able to outline the correlation between skills, knowledge, experience and expertise

Report writing or recording the assessment was often raised in response to assessment skills. The belief that written assessment tools helped to direct the assessment and the assessor was commonly cited, however some interviewees regarded prescriptive assessment tools negatively, describing them as a mechanism to dispense with experience and skills. As one nurse described,

"I think it's a fundamental need to go back and look at the assessment skills. I know you can bring in any tool but if a person's assessment skills are crap then they are crap. No tool is going to fix that" (N010)

#### **9.2.6.3 Education**

The role of education in providing a framework upon which assessment skills could be developed was evident throughout many interviews. This took into consideration the role of assessment models as well as written assessment recording tools. Whilst there was general consensus that skills, knowledge, experience and expertise were applied to assessment processes and recorded on assessment tools, the practical reality often reflected a belief about overemphasis on models and tools directing the assessment process. This led some interviewees to reflect on the role of professional education and the value attributed there to assessment skills. The difficulty in being able to teach and subsequently evidence the achievement or attainment of assessment skills was raised by several assessors who considered professional training as lacking the development of practical assessment skills. The role of education and the contribution it made to both the underpinning assessment skills and subsequent experiential components of these was raised by health and social work assessors alike.

Many nurses during the interview process were critical of the basic training they received on assessment. For many professionals, assessment was considered the critical component of all their activity and therefore justified the largest investment of time and effort. The degree to which assessment was taught and the realities of its application discussed during professional education appeared limited. Some interviewees felt the training they received on assessment was too theoretical and lacked the balance of daily professional pressures: factors which the assessor tended only to become familiar with following formal training.

The value of contributions made by newly qualified staff was nevertheless cited by several interviewees who regarded them as having the opportunity to be needs-led in their assessment due to a lack of awareness of the pressures which inevitably were exerted upon assessors from internal and external sources. The need to protect and nurture that needs-led focus was highlighted by several interviewees although for the majority, experience often overtook the innocence of newly trained staff, causing some to become cynical about assessment skills and the ability to successfully address needs.

For some interviewees comparisons were volunteered between the ability of health and social work staff to assess and address needs. For different reasons each professional group in the main considered themselves more proficient in the assessment of need.

No matter the degree to which assessment skills, education, knowledge, expertise were applied, many interviewees returned to the issues of client and carer preference and cooperation. Despite factors which appeared to positively influence the assessment process such as education, the fact remained for many assessors that should clients refuse recommendations, then no amount of experience or expertise would change things quickly. The need to work with clients and encourage them to accept support was frequently indicated; still many assessors recognised the essential nature of client compliance in order to make the assessment of need and subsequent methods of addressing need successful.

Experience was clearly an influential aspect of the assessment process and included several components such as expertise, education, assessment skills. One aspect which was identified by several interviewees from each professional group was the role that intuition played upon the assessment process and the extent to which it influenced the assessor's perceived ability to address needs.

#### **9.2.6.4 Intuition**

Professional intuition appeared to be a skill, which whilst difficult to describe had a particular and significant effect on an assessment and its outcome. Intuition was used as the term to describe the factors which were difficult to verbalise: the unseen aspects of assessment which though invisible and often unquantifiable, were very tangible to professionals. Experience appeared to sharpen professional intuition and, in some cases assessment had become such an intuitive process that interviewees had great difficulty describing the assessment process.

Intuition was described by several interviewees as the distillation of experience, expertise, education and knowledge, and as such could not be described in the absence of these factors. Professional intuition, like experience and expertise appeared to enable assessors to make predictions of the outcome of care or the urgency of need. Whilst the specific elements of professional intuition were less likely to be described during interviews, some respondents did describe situations whereby they were forced to reflect upon professional intuition, rationalise decisions and identify stages within complex processes.

The attainment of professional intuition was often described as something that could only be achieved with experience. The ability to trust one's intuition was critical where assessments and their outcomes became dependent on it, however most interviewees balanced their intuition with additional knowledge, information and more tangible, evidence-based expertise. The influence of intuition and experience upon the assessment process and outcome could not and was not underestimated by interviewees who referred to several components whose combination led to experienced and evidence-based assessments of need. Closely linked to the influence of experience were components associated with communication and the assessor's ability to engage, negotiate and interact with clients, carers and professionals.



### 9.2.7 Needs-Led Assessment and the Influence of Communication

Communication was an area identified as crucial to the assessment of need and when interviewees considered their ability to address need, communication re-emerged as a category which exerted an influence over this process. In order to avoid duplication of areas already discussed, those components most often referred to by interviewees are recorded in Figure 33. Whilst there remains a degree of duplication the extent to which these elements impact on the interviewees' ability to both assess and address needs will be considered in this section.

Influential Factors Identified	Frequency of Responses by Professional Group				
	Nursing	SW	Housing	CPN	GP
Client/assessor relationship	17	22	1	3	0
Manage expectations	10	18	4	1	1
Negotiate with professionals	14	8	0	3	0
Persuade clients	3	4	2	2	0
Family demands	0	9	0	0	0

**Figure 33 Communication: Factors Volunteered as Influencing the Extent to which Needs could be Addressed**

Categories remain relatively broad in scope in order to reflect the overarching influences on the interviewee's ability to address needs. The most frequently cited area of influence was the client/assessor relationship which developed during the course of the assessment and then during subsequent interventions. Several elements were identified by interviewees as influencing the assessment process through the client/assessor relationship. Factors such as public perception of statutory intervention, client and carer perception and preference, resource availability and assessor honesty were amongst the components identified

as influential in the assessment process and subsequent assessment related activity. Key areas are now considered in more detail:

#### **9.2.7.1 Client / Assessor Relationship**

Interviewees were particularly aware of how they were perceived as individuals and professionals and were conscious of the barriers caused by negative perceptions. If clients failed to relate to the professional as an individual then the potential of the assessment resulting in positive outcomes was considered unlikely. The realities of interpersonal issues as well as professional communication skills were not ignored by interviewees, many of whom had learned through experience that effective interaction with clients was a prerequisite for good assessment skills and successful outcomes. The reality that not all professionals interacted well with all clients at all times, was acknowledged by interviewees. Often this was related to the client's perception of the professional: where this was poor, successful communication was jeopardised.

The ability of clients to not only tolerate but to comply with professionals was highlighted as critical to the successful delivery and outcome of assessments. Client tolerance (or compliance) was often influenced by the general public perception of organisations: this was a sentiment raised frequently by interviewees who were sensitive to the involvement of statutory organisations. The extremes with which organisational involvement was viewed, reflected the extent to which clients communicated specific pieces of information.

"People present certain information and I think just by the fact that you say you are a social worker, an assessor, you put up a barrier straight away because people perceive you as a professional and then they can take two routes: they will either tell you nothing or they will tell you everything because they feel they have to" (H001)

The requirement to ensure effective information is communicated to the client and by the client was alluded to by interviewees. The basis of good assessment skills appeared to be rooted in effective communication skills which ensured the appropriate gathering of information and recommendation for support. The need to gather information, however intrusive, was indicated as a necessity, with the emphasis being on maintaining open channels of communication between the professional and the client.

The skill with which interviewees approached potentially difficult situations and ensured that information was communicated, exchanged and shared where appropriate was evident throughout the interview process without specific reference to communication skills by those being interviewed. Communication and information gathering were the methods by which assessments were constructed and conclusions drawn, therefore the ability to expertly extract the right type and amount of information without offending, causing concern or being perceived as threatening by clients and carers were areas described by interviewees. The ability of assessors to undertake these types of activities was debated by interviewees, who regarded certain professionals as more effective in managing the competing demands of a needs-led assessment,

“Assessment is your perspective, its gaining an external perspective of someone’s internal requirements. Maybe a social worker realises there is only so much they can do and if they can’t cope at home, get them into care. That is a social work problem – funding. Put them at the cheapest option not the best option” (N009)

Not all social workers contested the statements made about financial components or restrictions in their ability to address needs. Some interviewees made explicit reference to the financial or resource restrictions faced by community care staff and described how this would be managed and rationalised when information was shared openly and honestly with clients.

### **9.2.7.2 Manage Expectations**

The need to be open and honest was reflected in several interviews however, when it was raised as a prerequisite, it was often counterbalanced by the need to be realistic with clients and carers about their expectations of professionals and resources. Managing expectations appeared to be a skill applied during the assessment process and subsequent assessment related activity including resource recommendation or referral. The regularly volunteered strategy to deal with client expectations was honesty from the outset about the process and potential outcomes. This for many interviewees, deflected client disappointment, practitioner frustration and averted confrontation by demanding clients and/or carers.

The benefits of openness and honesty were reflected by most professional groups although their general ability to manage expectations was an area which influenced the extent to which they were able to address needs. This was raised more often as a concern by social workers than health care workers, although there appeared to be concern across the professional groups. One area identified was the potential to raise people's hopes only to find that the resource required was unavailable. Many interviewees appeared to accept personal responsibility for falsely raising people's expectations and then letting them down. The repercussions for clients, carers and professionals appeared to make assessors very cautious about what expectations they allowed to be raised. More often than not, effort was made to minimise expectations in order to avoid later disillusionment should failure to deliver occur.

Equipping clients and carers with the knowledge of resource constraints which might lead to delays in resource delivery appeared to engage clients as partners in the assessment process and to some degree appeared to dilute client dissatisfaction with services. Interviewees used this as a tactic to ensure that needs were addressed to the best of their ability, whilst maintaining a reasonable level of client safety and

satisfaction. Engagement of clients in the assessment process including the factors considered influential in the ability of professionals or organisations to address needs appeared to be a common component of the assessment process.

In some cases the requirement to settle for less was the result of the failure of resources to appropriately respond to needs: in other cases it was a realignment of the client's and the professional's perceived needs. Regardless, what was provided was considered appropriate, realistic and achievable. Interviewees described their role as assessors as including the identification of need, the setting of realistic goals or recommendations and resource interventions. The multiplicity of components led many interviewees to determine assessed need based on professional perspectives, the likelihood of resources being available and accessible, and clients/carers being cooperative,

The ability to manage expectations not only applied to situations where more was expected from professionals and organisations than was able to be delivered but also where professional expectations were not met due to client or carer refusal. Regardless of reasons behind managing expectations, professionals appeared to engage the same skills, knowledge and expertise to identify a middle ground where all sets of expectations were managed appropriately.

Where resources were limited professionals described the need to work harder at managing expectations by resorting to alternative interventions, considering client coping mechanisms, identifying the availability of informal care. Failure to meet needs was an area that most assessors endeavoured to avoid. Most identified mechanisms of managing expectations such that needs were to some degree addressed. Concerns over risk and professional litigation coloured much of the discussion about the assessment process and ways in which needs were identified and addressed. The professional dilemma created as a result of identifying needs, attempting to manage expectations, and address needs appropriately was described in detail by many interviewees. Many

professionals had personal experience of undertaking assessments where resources failed to adequately address the needs identified. For many assessors this created a perverse incentive: the identification of unmet needs, despite being considered good assessment practice, often had a negative effect on the carer and client and the relationship they had with the professional.

The ability to adequately manage individuals' expectations in the knowledge that effective resources could not respond or did not exist conflicted professionals. However the requirement to present a wider picture of the resource gaps within communities was an area described, but not always supported by interviewees. Some rationalised this in their minds by making a mental separation between the assessment of needs and the planning of care. This appeared to assist in the completion of a needs-led assessment and resource-driven care plan however it also alerted professionals to the requirement to manage expectations by not falsely raising hopes of resources which could not respond.

### **9.2.7.3 Negotiate with Professionals**

Interviewees identified the requirement to negotiate effectively with other professionals in order to progress assessment related activity. The contribution of different professionals to the assessment itself was considered invaluable however interviewees mainly referred to the requirement to ensure effective channels of communication between professionals in order to facilitate access to resources (particularly those managed and authorised by other professional organisations). For such reasons, the need and ability to negotiate with other professionals was raised as a factor which influenced the interviewees' ability to address needs within health care more so than social care. The perception that social workers had more direct access to resources and funding than nursing staff led to the referral from health services to social work services, requesting access to resources. The quality of interprofessional relationships was therefore regarded by several interviewees as critical to

the success or failure of such transactions. Personal contact and professional relationships between organisations and their practitioners were elements considered crucial in maintaining effective and productive communication channels. This was considered alongside alternative methods of sharing information including written assessments, referrals, and faxes,

“You maintain that personal contact with people and communication becomes more humane rather than filling in a form” (N041)

The positive benefits of working collaboratively and negotiating well with professionals was counterbalanced by poor experiences identified by many of the staff interviewed. The general experience was one of separation of roles between professional organisations. There also appeared to be a perceived transfer of responsibility from one professional group to another when a referral was made. In practice there was no evidence to support that this assumption was based on reality. In many cases referrals were made and not acted upon within the timescale expected by the referrer. Whilst organisational constraints such as resource restrictions, funding issues, poor staffing were cited as reasons for non response, often interviewees identified factors more fundamental than professional, institutional issues. The most common complaint was in relation to poor communication and in particular, difficulty in contacting the appropriate professional.

The simple ability to hold a conversation with another responsible professional and exchange important and relevant information appeared to elude many interviewees. Whether deliberate or coincidental, the consistency with which phone calls were not returned caused a great deal of frustration and a sense of powerlessness amongst interviewees. The result was the transfer of blame and a lack of trust or respect for other professional groups particularly when resources failed to respond. Interviewees described the need to persistently hound organisations to mobilise support or to pressurise professionals into responding to needs

which had been identified. In such cases interprofessional relationships were not considered particularly amicable or effective.

"You use your leadership skills in thrashing the agencies into action over needs: taking no snash from others" (N028)

The extremes in responses and strategies to negotiate with other professionals appeared to reflect a good cop/bad cop approach. The perceived urgency of situations caused practitioners to dispense of professionals niceties and cut to the chase. Other professionals took a longer term view which held in higher esteem the value of interprofessional relationships and invested time and effort, ensuring that these were maintained and remained effective regardless of the urgency of need.

#### **9.2.7.4 Persuade Clients and Manage Family Demands**

Another factor mentioned by interviewees in relation to communication issues influencing their ability to address needs, was the capacity to persuade clients to accept support where this was considered appropriate. For some interviewees, the need to not only advise but also to persuade, in order to facilitate client compliance was an unforeseen skill professionals had to acquire. In many cases this was not something they were able to learn through taught lessons but was gained through experience and application of various approaches.

This was reiterated by one of the GPs interviewed who described her perception of social work as an organisation promoting client's rights regardless of the level of need,

"I think there is general tendency of the social worker being told that they shouldn't be seen as pushy or making people accept things: they should not be seen to be going against their client's wishes" (GP002)



Whether the client's right to self-determination was a value adopted through organisational osmosis or the result of personal, professional experience, was a debate outwith the scope of this study, but it was an area where particularly strong views were expressed by various professionals. Housing staff expressed similar professional views about their role in persuading clients and the consequences of not being able to do so.

The strategies adopted by individual practitioners to successfully persuade clients to accept services appeared to range from similar extremes as those developed to persuade or negotiate with other professionals. Some emphasised the positives benefits for clients and carers whilst others highlighted the risks of failing to comply. Regardless of the approach there appeared to be a general understanding that the decision to accept or refuse resources remained with the client and their decisions were respected when all attempts at persuasion failed.

The ability and are times, requirement to persuade clients to cooperate with recommended resource interventions was sometimes made easier when family members were supportive of the professional's perspective and were able to engage with and persuade the client more effectively. This sometimes had the converse effect, where families exerted demands upon professionals and organisations which were considered unreasonable or unattainable. In some instances demands were made without the knowledge or consent of the client and were perceived as based upon the families' need to reduce risk and minimise their level of intervention (which maybe considered in excess of what an informal carer was capable with delivering or dealing with). The pressures that family demands exerted upon professionals were articulated clearly by interviewees who described the ways in which these demands could influence both the assessment and the manner in which needs were addressed. References to the pressures exerted by family demands were made by social work staff although it was identified during earlier chapters that the input from others including family members was reflected in the assessment process. Some social workers did describe situations whereby assessment

contributions from family members became more than opinion and were presented as a demand either to the professional directly or to more senior members within the organisation.

Social workers appeared to find themselves in an unfortunate position whereby their goal to identify and address needs of individuals using the skills, knowledge, experience and expertise, was compromised by a myriad of internal and external pressures. However the pressures exerted upon them from various directions including organisational constraints and values and then client perceptions and family demands, often led to activity which achieved desired outcomes but compromised the integrity of the process they as professionals adhered to.

#### **9.2.8 Needs-Led Assessment and the Influence of Needs Assessment**

Needs assessment related materials were cited by interviewees as having an influence on the extent to which needs were able to be addressed. This included the recording tool for needs assessment and related documentation associated with assessing and addressing needs. Figure 34 outlines the components identified in relation to needs assessment which were volunteered by professional groups.

<b>Influential Factors Identified</b>	<b>Frequency of Responses by Professional Group</b>				
	Nursing	SW	Housing	CPN	GP
Assessment tool	9	27	0	7	0
Excessive assessment paperwork	10	10	2	4	0
Referral paperwork	8	5	1	2	0
Assessment model	6	3	0	2	0
Care Plan	1	2	0	3	0

**Figure 34 Needs Assessment: Factors Volunteered as Influencing the Extent to which Needs could be Addressed**

Needs assessment was a term used to describe the identification and recording of needs related information and appeared to vary between professional groups.

The ability to be needs-led during the assessment process was influenced by the recording tools used by professionals and organisations. Interviewees were particularly honest about the factors which averted them from being completely needs-led. Having described and discussed many of the frequently volunteered components, the area of needs assessment was deconstructed. This was also an area (like communication) which was identified during earlier questioning about the factors that influenced the interviewee's identification of need during the assessment process. It did appear that as well as influencing what was recorded as a need, the needs assessment recording tool also influenced the assessment outcomes and therefore the interviewee's ability to be needs-led.

"It is frustrating because although you are going out for a needs-led assessment, it's often the resources that you know you have got that you will gear your assessment towards" (SW032)

#### **9.2.8.1 Assessment Tool**

The needs assessment recording tool was identified by interviewees as affecting their ability to address needs. This was also highlighted in earlier chapters focussing on the identification of need and factors which directed information gathering. The majority of responses in this area were offered by social work staff who identified difficulties in adhering to the structure of a written document whilst applying an unstructured (or semi-structured) interview process to elicit needs.

"You are not getting that holistic assessment picture of people's needs if you stick to the assessment tool: you are going to get a narrow view of what you are looking for" (SW006)

The perception that structured needs assessment tools constrained the assessment process and inhibited the assessor's ability to extend the scope of the assessment was highlighted by several interviewees. Many agreed the benefits of standardised information recording however others experienced restrictions in practice. The expectation that assessment skills would be applied to a situation and then recorded using an assessment tool, was taken for granted by many interviewees. During the study this did not always appear to be the case, with assessment tools apparently replacing good assessment skills, practice, experience and expertise. Reliance on the assessment tool seemed to lead to complacency amongst interviewees.

The fear that prescriptive assessment recording tools would lead to professionals assessing within the parameters of the tool and dispensing with their professional assessment skills and experience was sometimes highlighted. The value attributed to professional assessment skills suggested that needs assessment recording tools should be designed and used for the purpose of recording and sharing standardised assessment information and not as a script for directing assessment related activity.

The likelihood of clients accessing their needs assessment was raised by several interviewees and this appeared to influence the information recorded on paper. This did not mean that unmet or unmettable needs were not identified, but in many cases they were not recorded on paperwork which was likely to enter the public domain. The requirement to reflect a balanced, professional description of need, identified through a rigorous process of information gathering, appeared to be reinforced by the knowledge that information would be shared with clients and carers. Information sharing did appear to influence what was recorded on assessment correspondence particularly when the assessment was likely to be shared with other professionals, whose contributions and interventions may be required.

"It's good to have it on paper because nurses are notorious for storing things in their head and that's alright as long as you are the

only one involved, but if you are away and this information isn't down anywhere then a lot of important information will be missed" (N008)

Nursing staff were described as more likely to record minimal information whereas social work staff were described as recording very detailed information. The need to ensure accuracy and reliability when recording assessment information was reinforced by interviewees who could readily cite instances where a lack of recorded information led to poor care and outcomes for clients. Written information about needs was considered by interviewees as creating a responsibility to respond, particularly when that information was shared with the client and the carer. A known inability to respond to needs therefore acted as a deterrent from recording unmet needs in the first place.

The ability to record need and justify resource intervention on an assessment form was identified as a helpful component by many interviewees, mainly in social work. This involved the ability to record different perceptions of need and interventions. The orientation of the needs assessment recording tool therefore became an important consideration for social work staff who identified the need to specifically record certain components and/or be reminded to record specific components. The community care assessment forms were described in detail by social work interviewees who were able to recall, unprompted the general headings for each section and therefore the structure followed by their assessment tool.

Standardisation of professional assessment forms used daily by interviewees, structured the assessment of need as categories recorded on those forms. Due to the familiarity most interviewees had with the paperwork, many could recall the categories without reference to the forms and volunteered that this helped to structure their assessment process. For many interviewees the forms acted as an aide memoir, ensuring that all relevant need categories were covered.

The benefits of standard assessment recording tools were listed as ensuring equity of identified need, resource intervention and a practical reminder to assessors to collect and record information in a way that facilitated information sharing within and across agencies. The manner in which the assessment recording tool was used varied between interviewees, with some insisting the assessment process remained informal and free of any written paperwork whilst others saw the merit of recording information as it was collected, and actively sharing the evolving assessment with the client, allowing contemporaneous amendments.

The accurate reporting of needs, both unmet and unmettable was an area which was considered the remit of the needs assessment recording tool. Tools which included sections about unmet needs were more likely to have this section completed whereas tools which failed to request the recording of unmet need were often devoid of this detail. The degree to which the needs assessment tool was perceived to drive the assessment varied between one interviewee and another. Due to the differences of assessment tools used by those interviewed, little comparison could be made about the effectiveness or otherwise of utilising a prescriptive recording tool and the subsequent influence this exerted upon the assessor to behave in a particular manner. Some interviewees welcomed the structure offered by a prescriptive assessment tool whilst others felt constrained by it. Standardised information sharing between agencies was perceived to benefit by the use of prescriptive assessment tools however others perceived this as a restraint on their professional autonomy and practice.

#### **9.2.8.2 Excessive Paperwork (including Referral Paperwork)**

The recording of assessments led interviewees to criticise the amount of paperwork or desk based activities undertaken. This was identified as a factor which influenced the extent to which professionals could address need due to factors such as: the perceived barrier caused by paperwork

to the professional/client relationship, time spent perfecting paperwork, the degree of duplication between agencies and, the lack of evidence that effectively recorded need resulted in better outcomes for clients.

There was a perceived lack of standardisation between the assessment recording tools used by different professionals. When the assessment was used as the basis to refer and justify the provision of care and support this became an issue for staff. Often assessments were not accepted at face value and repeat assessments (in the language and format desired by the receiving organisation) were regularly undertaken. The benefits of standardisation were not always considered with respect to the direction it might take assessment in. The most frequent reference to paperwork involved the degree to which information was duplicated between and within professional organisations. The frustration this caused interviewees, clients and carers was palpable,

“From the carers’ point of view – they probably feel that ‘I have just went through all of this with the district nurse and now I have got to go through it all again’” (N004)

For some interviewees, engaging in assessment and the completion of assessment related paperwork meant embarking on a lengthy paper trail: some interviewees were very frank about their aversion to becoming involved, particularly if, at the end of the assessment process, another professional organisation was considered responsible to address the needs identified. Whilst this was communicated by a minority of assessors the excessive nature of assessment related paperwork did appear to influence the extent to which needs were identified and addressed.

The degree of frustration expressed by staff (mainly social work) referred not only to the recording of assessment related material on paper but also the electronic recording of information. For many interviewees their motivation for entering their profession was centred on client care. This was juxtaposed by the degree to which the recording of assessment information determined time allocation and directed assessment activity.

“Paperwork, bloody paperwork: you spend more time sitting in front of that damn computer. The fact that we all have computers sitting on our desks speaks volumes. I spend more time on that bloody computer” (SW019)

In addition to recording the assessment, several interviewees made reference to the requirement to repeat information on predetermined referral forms or their experience of having their assessment duplicated by other professional organisations following referral. Health staff more so than social work staff described these experiences and the influences exerted by the necessity to translate existing recorded assessment into referral paperwork. In some cases, referral to other agencies was made with the specific request for a professional assessment. It was the experience of several nurse interviewees, that where social work services were perceived as a requirement, a social work specific assessment had to be completed before services were introduced. Interviewees referred to their own experiences of making referrals to social work services, awaiting client allocation, contributing to the completion of another assessment, only to have the client refuse care at the end of the process. The negative influence such experiences exerted upon practice and practitioners was evident.

Interviewees were presented with the dilemma of completing a needs-led assessment with the potential of client non-compliance. This brought into question the value of the time consuming assessment process. The benefits of assessing for services were at times, more justifiable than the perceived benefits of pursuing a needs-led assessment. The value of organisational specific referral and assessment forms were questioned by interviewees who identified poor experiences and failed to identify tangible benefits. For many professionals, completion of referral forms was a bureaucratic, means to an end and failed to take cognisance of existing professional assessment documentation and skills. This also added to the perceived excessive documentation and amount of duplication which existed within and between professional organisations.



### **9.2.8.3      Assessment Model (including the Care Plan)**

Amidst the perceived excesses of assessment recording and referral paperwork, interviewees highlighted the influence of assessment models within both the assessment process and the extent to which they were able to address needs. Nursing staff appeared more reliant on assessment models and as indicated previously, nursing assessments were heavily determined by Roper, Logan and Tierney's model of ADLs. The framework for assessment outlined within this model appeared to create a set of parameters within which nursing staff assessed need.

This was sometimes criticised by social work staff, whose application of a multitude of assessment models was perceived to allow them the freedom to assess outwith any modular constraints. The degree to which assessment models were consciously applied within assessment scenarios was questioned: the repetitive nature of applying assessment models meant that the process became automatic and intuitive. Some interviewees tried to describe models, whilst recognising that professional interaction with the client often became an informal discourse.

Assessment models, whether consciously or subconsciously applied, influenced and directed assessment related activity of professionals. The degree to which assessment outcomes were dictated by the assessment model adopted often depended on factors like professional training, length of experience and knowledge of compounding factors. In practical terms interviewees did describe the application of assessment models as an idealistic component and provided instead examples of the realities of assessing and addressing needs within a limited resource environment. The assessment model which underpinned much of their practice and which upheld principles such as needs-led assessment were considered to direct assessments but were not always considered robust enough to manage the pressures that reality exerted upon the professional, the process they were undertaking, and the organisation within which they operated.

The activity of care planning was rarely separated from that of assessment with many interviewees amalgamating the assessment of need with the planning and delivery of care. This occurred to such an extent that needs were often described in terms of need for a particular service, with some assessors stipulating the level of service required. Few interviewees regarded care planning as separate from the assessment process: this is reflected in the small numbers of interviewees making any direct reference to the care plan.

The practice of planning care during the process of assessing need was identified by almost every interviewee; however those professionals responsible for authorising assessments appeared to be more concerned with the separation of needs assessment and care planning. This was a trait observed within social work moreso than nursing and seemed to reflect the business processes they operated to allocate resources. Senior social workers in particular referred to the need to separate the process of assessment (during which needs should be identified) from that of care planning (during which resources should be identified), however most recognised the difficulty in applying this principle in practice.

The value of separating needs assessment from care planning, although acknowledged, appeared unrealistic and unachievable due to constraints on professionals and organisations. The ability to perform needs-led assessments appeared to require a separation, either mentally or on paper, between needs assessed and care planned. With the knowledge of resource restrictions and other pressures such as client compliance, organisational demands, the ability to maintain that separation appeared to become more difficult for interviewees. Similarly the repetitive nature of assessment and resource access, led many professionals to retreat to learned behaviours. Therefore certain needs tended to result in similar outcomes as experience had taught professionals that those outcomes were the most easily accessed or successfully provided.

### **9.2.9 Needs-Led Assessment and the Influence of Geography**

One area that was identified as an influencing factor by almost half of those interviewed was the geographical area the person resided in. Access to resources and professionals varied from one area to another which led to inequalities in service provision across relatively small areas of North Glasgow. Consideration of location in relation to resource access and availability appeared unavoidable for many interviewees. Assessments and the ways in which needs were addressed were clearly influenced by postcode despite interviewees acknowledging the unfairness and lack of equity. Like many other aspects, professionals felt powerless to do anything about this.

Professional acceptance of a system of geographical inequality was varied, with some interviewees describing themselves as being particularly proactive about restoring rights of access for clients. This meant exerting pressure on other professionals to mobilise resources regardless of geographical or other eligibility criteria. The need for equality across agencies was highlighted by many interviewees.

## **9.3 Chapter Conclusions**

Factors considered influential in assessing and addressing need were extensively explored in the course of the study, with each of the main themes deconstructed within this chapter. Four themes were cited more frequently including: resources, compliance, risk and organisational factors. These have been considered in greater detail highlighting the complexity of internal and external influences exerting pressures on practitioners to act in a certain manner. For some experienced practitioners, these influences were so commonplace, that needs were considered in relation to them: for instance need expressed as a need for a service known to be both available and accessible was vocalised regularly. Where few resource options existed, practitioners were forced to refer to the same limited services therefore repetitive actions resulted in habitual, subconscious behaviours, often where needs were considered

as resource requirements. The opportunity to think innovatively regarding resource intervention appeared to diminish as habitual resource referrals increased.

Other factors appeared to determine the identification of need as well as knowledge of resource availability and accessibility: these included the likelihood of the client or carer to concur with recommended interventions. Pre-empting client choice and positioning client preference either at the centre or in parallel to decision-making regarding assessed need and interventions appeared to influence the extent to which assessments could be needs-led. For some interviewees 'needs-led' equated with 'client-driven'. For the majority it involved a compromise between professionally and personally defined need within structures and models of assessment. The medical and social models of care were frequently cited by interviewees but rarely consistently defined. Nevertheless adherence to one or other of these models did appear to direct and influence assessment related behaviour.

Perceptions of risk also emerged as key factors influential in the approach to needs-led assessment. The degree to which risk translated concerns into needs, and then needs into considerable risk seemed to differ between professional groups. Risk tolerance appeared higher within social care services with health staff appearing risk averse in the responses given to interview questions. This clearly motivated individuals into action: where risks appeared significant, needs were defined less prescriptively and support was mobilised to manage overall risk as opposed to individual needs. The outcomes of assessments were therefore evident by the resource interventions identified. The urgency with which interventions were pursued was largely dependent on the perceived significance of the risk. Risk-driven assessments rarely centred around client choice and compliance: risk appeared to overwrite individual rights to self determination. This was evident across professional groups.

Organisational factors, including organisational values appeared to play a role in determining a practitioner's ability to undertake needs-led

assessment. The structures, values, purposes and cultures of organisations provided a framework within which practitioners operated. Where this was supportive of needs-led assessment, professionals were able to practice this approach with a degree of reassurance. However where there was an expectation that needs, once identified, would be addressed, practitioners appeared to retreat from the practice of needs-led assessment and displayed habitual resource-driven behaviours.

Responses arising from earlier questions such as 'how do you identify needs?' re-emerged when asked to describe factors which affected interviewees' ability to address need. Communication, needs assessment, experience and an awareness of organisational values appeared key to the identification process and then the factors influencing what was recorded as a need and what was considered an appropriate response to that need. Separation of identified need and assessment outcomes was uncommon across the study group with most interviewees identifying a 'need for' as opposed to a 'need with'.

## **CHAPTER TEN**

### **10 CONCLUSIONS FROM THE STUDY**

#### **10.1 Chapter Introduction**

It was the purpose of this study to consider and compare needs-led assessment as it occurred in a community care setting. The sample group included mainly health and social care professionals with a small number of housing staff and GPs included for contextual reasons. The study explored the extent to which needs-led assessment was influenced by internal and external factors and proposed to determine whether the concept was a practical reality for professionals.

The main research questions were explored through the use of sequenced vignettes and semi-structured interviews. Research questions included:

- What factors influence the assessment of need?
- What is the relationship between needs identified and needs recorded?
- How is need defined and conceptualised by assessors?
- What factors influence the extent to which needs are addressed?
- Are assessors influenced by their ability to address (or not address) need whilst undertaking an assessment of need?
- How is assessment defined and conceptualised by assessors?
- What professional differences (if any) exist with regard to the assessment of need and addressing need?

Supplementary questions also considered:

- How important is it to perform needs-led assessment?
- What are the benefits or drawbacks of performing needs-led assessment?

- Does performance of needs-led assessment influence the outcome of the assessment?

This chapter aims to consider the main results yielded in response to the study questions and compare themes with those identified in similar studies outlined in the literature review. Consideration of definitions of need and assessment, perceived professional differences, factors influential in assessment and the extent to which needs are addressed have been outlined in Chapters 6, 7, 8, and 9. Deliberations will not be repeated: this chapter seeks to identify the main themes and summarise key findings including critical reflections and recommendations should the study be repeated.

## **10.2 Needs-led Assessment – Idealistic Principle or Practical Reality?**

Translation of community care policies into practice has signalled the shift from a traditionally service driven to a needs-led approach to assessment and service delivery. Clarity of purpose and practice is imperative for such a shift to maintain direction and success. Both health and social care services have traditionally purchased and provided care as defined and identified through specialist assessment procedures undertaken with both individuals and communities alike. Community care means different things to different people and professionals. Definition of terms and interpretation into practice has highlighted the need for shared understanding and interagency collaboration. Differences of interpretation may lead to inconsistencies in the definition of need and assessment. Similarly, lack of clarity concerning the purpose and perceived promise of a needs-led assessment is further complicated by conceptual and operational inconsistencies between those disciplines. Performance of assessment that achieves the goals set out in government guidelines will depend very much on firstly; professionally shared commitment to the principles of community care, secondly; professional identity with policy guidance, thirdly; organisational structures which

facilitates the process and; finally the political support which accommodates a shift as radical as that envisaged by the new legislation.

The concept of needs-led assessment has been extensively debated in literature and practice since the early nineties when its application became a reality for community-based professionals. Whilst studies have identified the complex nature of the decision-making process surrounding need and assessment, outcomes for service users have remained relatively unchanged (Bryans and McIntosh 1996, Jordan and Wright 1997). The process of identifying need via a professional assessment process, planning appropriate care and accessing/implementing support has underpinned professional practice for years and continues to provide the framework upon which evolving principles are incorporated. Needs-led assessment has been the unspoken motivation behind professional practice, long before it became enshrined in policy. The implications of its application amidst personal (i.e. client), professional and organisational demands have been explored throughout this study as have factors considered influential to the general process.

The term 'need' was used universally by interviewees however when asked to define it, most study participants experienced difficulty finding words devoid of service terminology. Need was rarely identified as a 'need with' but more often a 'need for' therefore the outcome, usually resource-driven, typified need. Interviewees frequently defined need as the requirement for resource intervention unlike Culyer's (1995) description of 'capacity to benefit'. Perceived from the clients' perspective, needs were expected to be associated with a service outcome: descriptions of need as states of being were described as lacking purpose by those interviewed.

The concept of need whether professionally defined or personally perceived focuses the assessment process and is responsible for shaping outcomes. The NHS and Community Care Act (1990) signalled an explicit shift away from a service-led to a needs-led approach to assessment and delivery of care in both health and social work services, with greater



emphasis on user choice and participation in assessment processes. Much criticism has been levelled at traditional systems of care being defined in terms of resource availability as opposed to individual need: perhaps due to the tangible and quantifiable nature of recording service responses as opposed to subjective entities such as needs. Nolan and Caldock (1996), suggest that there is a failure to adequately define what 'needs-led' actually means and that this is exacerbated by the fact that practitioners seem to have no vocabulary for defining need without reference to 'service terminology' (DoH 1993). The dichotomy, which prevails, involves a definition of need in terms of desired outcome or eligibility criteria. This was clearly reflected throughout the study and expressed consistently by practitioners across professional groups.

Assessment as defined by interviewees appeared to encompass a variety of stages which at one point in a professional's career were distinct components. Assessment was described by most health and social work staff to encompass identification of need, resource planning, goal setting, service implementation and review. These distinct entities seemed to merge over time and with experience to become what was termed the 'assessment'. As a consequence, professionals were often accessing resources as needs were being identified: in some cases, care plans were actioned prior to the completion of the assessment. Whilst most health and social care staff recognised the importance of each stage and its cyclic nature, practical reality and time constraints meant that each merged and was managed as a single process. The implications for needs-led assessment were considered by only a few interviewees who recognised that in the absence of a separate care planning mechanism, assessment included not only the identified need but also the identified resource intervention. The predisposition to assess for resources as opposed to identify needs, and then subsequently and separately consider resources, seemed to act as a deterrent to needs-led assessment.

The NHS and Community Care Act (1990) acknowledges and attempts to address some of the difficulties with assessment: these are listed by Caldock (1994b) to include, uncertainty about the nature and purpose of

assessment; assessments determined by the professional interests of the assessor; assessment not a precise definitive process and that; assessment with a tendency to offer what is available rather than what was needed. The focus of assessment is described, by Caldock (1993) as a shift from simply identifying the services a person might require to determining the full scope of their social care needs regardless of the existence of a service or availability of resources to meet such needs,

“the aim ultimately is to reach an agreed understanding and definition of needs from which point choices can be made and options identified” (Caldock (1993 p141)

#### **10.2.1 Recording Needs-Led Assessment for Individuals and Communities**

Cultural norms which become established in training and practice are difficult to challenge. In social care, assessment procedures have been described as structural imperatives within the organisation with any challenge threatening the very fabric of the system (Hewison 1996, Barnes 1996, Fagermoen 1997). According to McWalter et al (1994), attempts at conceptualising need and defining 'needs-led assessment' have succeeded only in extending the parameters, or as he describes, 'an exercise in exchanging one set of uncertainties for another' (McWalter et al 1994 page 215). Reappraisal of the principles fundamental to the assessment process does beg the question of the ability of an assessment recording tool to adequately document the comprehensive parameters of the assessment itself, bearing in mind that it requires also to be valid, reliable, justifiable and acceptable.

During the course of the study, the recording (including recording format) of needs-led assessment was often described separately from the identification of need: knowledge of assessment information sharing with clients, carers, professionals, other agencies caused interviewees to temper their record of need with that which reflected their ability to address needs (including unmet needs). This was described in a manner

which maintained their professional credibility and legal / ethical requirements to address needs within available limits, whilst accurately reflecting the client and carer's needs, wishes and preferences. Assessment of need in health and social care occurs at individual and population levels. The NHS and Community Care Act (1990, Section 52) makes statutory, the requirement that Local Authorities produce a formal plan for the provision of community care services in their areas. Whilst most interviewees recognised the importance of recording needs that could be met alongside those that could not, knowledge of legal ramifications and organisational inaction in response to unmet and unmeetable need deterred its recording. Within the social work study sample, documentation and protocols had been established to ensure unmet needs were recorded and collated for communities however many interviewees expressed frustration at this process as no discernible benefits were achieved and there was an underlying belief that needs were not aggregated centrally despite local efforts. Nurses were more pragmatic in their approach and described the requirement to be needs-led in principle but realistic (therefore resource-driven) in practice. Knowledge of unmet needs for individuals and communities in nursing appeared to have no formal means of reporting therefore information was often stored mentally. Both health and social work professionals recognised the long-term benefits of recording unmet and unmeetable need but both expressed concerns about their respective organisation's ability to manage that information effectively without leaving practitioners open to legal ramifications and raising local expectations.

Stalker (1993) records some of the challenges which have arisen as a result of recording unmet needs and suggests some reasons why professionals display reluctance to record these. Included are: excessive workload already undertaken by authorities, differing and at times competing agendas of various agencies involved, financial uncertainty and difficulty achieving a comprehensive overview due to the scale and complexity of the task. These views and concerns were expressed by various professionals during the course of the study and provided a rationale for the ways in which needs were recorded. Interviewees made

reference to the unmet needs of individuals and communities and mechanisms whereby needs were identified and where able, addressed: the majority of respondents described needs elicited from individuals' assessments. Stalker (1993) describes several methods whereby community needs are identified. The distinction is made between data on a macro and micro level or that described as 'hard' or 'soft'. Quantitative or 'hard' data involves some degree of comparative need and is traditionally informed by demographic and prevalence rates, registers and utilisation of existing service provision. Qualitative or 'soft' data involves consultation with users and carers, information from complaints procedures, inspection units and individual needs assessments. The combination of collecting and recording data which includes elements of comparative, normative, expressed and felt need presents, argues Stalker, 'a more rounded picture of a locality', although one common concern is raised,

"The focus of forward planning is therefore placed on targeting, prioritising, redeployment of resources and improved co-ordination. This strategy inevitably raises the question of how able and willing authorities will be to undertake a comprehensive assessment of population needs" (Stalker 1993 page 8)

Assessment of population and individual needs raises concerns over equity and fairness. While neither is mutually exclusive, the two perspectives may not always converge. Harding et al. (1987) identifies a tension, which frequently exists between the demands created by planning for individuals and those pertaining to service development. The conclusion is drawn that individual needs are frequently 'compromised in the wider interests of medical/administrative convenience' (Harding et al. 1987 page 141). A study by Griffiths and Luker (1994) suggest that at times district nurses may withhold patient choice and involvement in care decisions because the support of colleagues and organisational demands take precedence over patients' needs. Furthermore restricted resources means that services offered are rationed in favour of the collective needs of the local population.

Many approaches to population-based assessment of need begin with the assumption that the needs of the individual must be subordinate to the public good (Stineman 2001, Stalker 1993, Bath et al. 2000). The public good as described by Lightfoot (1995) involves achieving the most cost-effective, maximum, overall health outcome from the use of scarce resources. Here the 'capacity to benefit' requires resources targeted to those with capacity to achieve the greatest gain from a given intervention. Clearly a conflict emerges whereby purchasers might be expected to favour overall economic efficiency in financial terms. This contrasts the social justice based approach which considers clients and carers as consumers to whom statutory services are accountable to (Lightfoot 1995). A review of literature suggests that differences in professional organisation, training and practice determine largely the approach to planning and purchasing of care for individuals and communities. Management of individual health and social care needs and individually tailored care plans within a climate of inadequate, inappropriate and at times non-existent resource outcomes have sparked debates regarding scarcity and equity. Smith et al. (1990) summarises the fundamental points in relation to health services,

"The debate resolves essentially into whether health and medical care should be used primarily to reduce health variance or to increase its mean. If it is to be viewed as contributing to the economic output of the nation or as part of the apparatus of social justice?" (Smith et al. 1990 page 187)

'Health of the nation' or 'health of the needy' appear two extremes of a continuum. 'Community Care in the Next Decade and Beyond' (DoH 1989) plans to do just that, however sceptics remain unconvinced in view of the juxtaposition position of rhetoric and reality (Hudson 1999, Rummery 1999, Bradley and Manthorpe 1993, Allott and Robb 2006). Harding et al. (1987) reiterate the need for a comprehensive means of data collection to inform the consultation and collaboration process, as a way of avoiding unrealistic, unachievable care outcomes,

"Multi-level data collection which are compared with current levels of funding and resources may help to avoid collection of "soft" or "blue sky" data with unrealistic needs statements" (Harding et al. 1987 page 142)

Lightfoot 1995 suggests that individuals' needs are frequently compromised in the wider interests of medical/administrative convenience and that purchasers are predisposed to favour smaller gains for the majority as opposed to greater gains for a few. Lightfoot (1995) describes the difficulties faced by care managers and health service clinicians who must match presenting needs of individuals within eligibility criteria determined by priorities set at a broader level. Here it is highlighted that while the stated aim in social care is to shift priorities in the direction of needs as defined by service users, it is yet to be proven feasible. The conclusion drawn is that 'if health care purchasing is driven by pragmatism then social care appears to be characterised by optimism' (Lightfoot 1995, page 110).

#### **10.2.2 Implementation of Needs-led Assessment**

The process of assessment indicated professional similarities throughout the study. Many respondents indicated its purpose as identifying need although in many instances this reflected the nature within which needs should and would be met. Service specificity was apparent across professional groups as they described the process of assessment. Rarely were outcomes withheld from definitions and interventions were frequently described. Richards (1994) asserts, with reference to community care guidance, that effective implementation of a needs-led approach depends on creating a clear separation between the task of needs assessment and care management. Therefore practitioners must distinguish between the assessment of need and the consideration of the service response to avoid predetermination of the outcome of an assessment. She commends that,

“To identify need appropriately, practitioners must have an unimpeded view, free from the distorting effect of service considerations” (Richards 1994 page 5)

One way to facilitate this process is the separation of needs assessment and subsequent decision making about eligibility. This depends on the concept of need operationalised independently of the agencies’ policies and guidelines (Richards 1994). Unless such a separation is maintained many authors (Davies and Challis 1986, Percy – Smith 1996, Young 2003, Worth 1999, Parker 2000) suggest that the distinction between service-driven and needs-led assessments becomes less apparent and meaningful: the consequence will be a definition of need in terms of eligibility criteria for specific service interventions.

When considering the process of assessment some professional differences became apparent: social workers (often described as applying a social model of care) spent more time on data collection and investigated background information including relationships, hobbies, motivations and other factors considered important in shaping individuals and personalities. The aim appeared to be able to view the world and the client’s needs from the client’s perspective, applying the client’s views and values to the presenting needs. In contrast nurses adopted a more professionally determined approach to assessment, utilising skills considered specialist to their profession. Whilst client and carer choice and values were identified as important, they were considered as supplementary elements to the professionally defined assessment of need. Many interviewees explained this difference as the result of the application of either a medical or a social model of care. Both health and social work staff were influenced by perceptions and preferences of clients and carers during an assessment of need. The distinction between the task of assessment and the process of assessment was often alluded to, with assessors referring to particular skills, approaches and areas of expertise directed at identifying and interpreting needs. Nolan and Caldock (1996) make the distinction between the assessment and the assessor as each contributes to the assessment process. Quality

statements are suggested that would identify a good assessor. These are outlined in Figure 35.

<b>Good Assessors will:</b>	
1	Empower both user and the carer, fully informing, clarifying their understanding of the situation and role of assessor prior to the assessment.
2	Involve rather than simply inform the user and carer, establishing partnership in assessment
3	Shed their professional perspective: be open-minded and prepared to learn.
4	Begin where the user and carer are: establish their current level of understanding including their hopes and expectations.
5	Be interested in the user and carer as people
6	Establish a suitable environment for the assessment which ensures privacy, quiet and sufficient time.
7	Take time to build trust and rapport, and overcome the 'brief visitor syndrome'.
8	Be sensitive, imaginative and creative in responding: users and carers may not know what is possible or available. For carers in particular guilt and reticence may have to be overcome
9	Avoid value judgements whenever possible and if such considerations are required, make them explicit.
10	Consider social, emotional and relationship needs as well as practical needs and difficulties. Pay particular attention to the relationship between the carer and the user.
11	Listen to and value the user and carer's expertise or opinion, even if these contradict the assessor's own values.
12	Present honest, realistic service options, identifying advantages and disadvantages, providing an indication of any delay or limitations in service delivery
13	Not make the assessment a 'battle' in which users and carers feel the need to fight for services.



Good Assessors will:	
14	Balance all perspectives
15	Clarify understanding at the end of the assessment, describe objectives and the nature of the review process

**Figure 35 Attributes of a Good Assessor**

(Nolan and Caldock 1996 p83-84)

Whilst assessors all demonstrated these attributes in varying degrees, several differences were noted by the author. Social work appeared more client-centred in their approach to needs identification and resource intervention. Nursing staff justified their professionally determined approach by the specialist knowledge they held about clients' conditions and prognosis. Nurses were also more conscious of inadvertently raising client's expectations and often expressed concern over professional litigation where needs were identified but not met to the satisfaction of the client or the carer. This was particularly troublesome when health staff were not accountable for resource access: their involvement often ceased at resource referral. This created some tension between health and social care staff where perceptions of need, risk and client choice varied, although most interviewees described methods undertaken in order to address, if only partially, needs that had been identified. Many interviewees became very persuasive or inventive in the methods used to ensure needs were addressed.

Organisational values was an area raised by health and social care staff during the study. Professionals appeared to adopt or adapt to the values upheld by their employing agency and often procedures existed which supported decision-making as an organisation and not only as an autonomous practitioner. Supervision was often cited amongst social workers as a formal and effective mechanism of reflecting on practice and continually improving skills and knowledge. Nurses lacked regular contact with line managers in a supervisory capacity but identified other mechanisms by which professional development occurred although there seemed to be a regrettable lack of time and opportunity to reflect on

professional decision-making: more use was made of informal peer related support. The influence of organisational values was evident throughout interviews although this was not always expressed explicitly by respondents. Terminology, reference to organisational priorities, models of assessment all contributed to the distinction between health and social care staff during the study. Several organisational factors are identified in the literature as influential in the assessment of need: each impact on the ability of a professional to perform an assessment that is needs-led in focus. Mixed understanding between disciplines of the notion of need and the assessment thereof lends itself to issues regarding inter-rater reliability. Twigg and Atkin (1994) argue that because of the absence of clear and explicit agency, policy and practice guidelines, professionals have to rely on their implicit knowledge. The three sources of implicit knowledge, describes Nolan and Caldock (1996) are: professional training and values, the culture of the office, and assumptive worlds. Ellis (1993), remarking on current assessment principles suggests that the process is often rooted in the professional identity of the assessor and is thereby limited as a consequence.

Focussing on Nolan and Caldock's (1996) theory of implicit knowledge, the factors motivating social care practitioners in assessing need are deconstructed: they suggest that the field of community care for older people is awarded a low profile and does not have a particularly strong theoretical base. These factors are exacerbated by a lack of consensus within departments as to what constitutes appropriate and effective interventions. However the basis of their reasoning lies in the existence and influence of 'assumptive worlds'. Despite difficulties in identifying supporting evidence that is not anecdotal, there is agreement that 'subliminal aspects' exert a real and powerful influence over the assessment process. Ellis (1993) describes the making of moral judgements about 'deserving cases' as the main factor determining who receives services and who does not.

These fundamental professional, cultural differences are often explained in terms of variations in philosophy, training, agendas, language and

ways of working. Similarly there are also indications that different groups of professionals may be unwilling to accept the assessment and recommendation of other professionals as sufficient to act upon (Smith 2001, Gambrill and Gibbs 2002, Webb 2001, Healy 2003, Bryans and McIntosh 1996). Reassessment by other professional groups to confirm or deny assessed needs would undermine the envisaged benefit of a single care manager with responsibility for planning and implementing care (Caldock 1993).

Runciman (1989) applies similar comparative principles to the assessment process of health visitors suggesting they experience difficulty working with older people because of a lack of a consistent focus or framework pattern for assessment. Bryans and McIntosh (1996), whilst considering the decision-making activity of community nurses identified intrinsic and extrinsic factors fundamental to the process. Here, the community nurse is described as a uniquely programmed and constantly self-programming individual. Extrinsic factors such as information derived from external referral sources contribute to the process of decision-making however emphasis is given to the place of intrinsic or intuitive behaviour. Bryans and McIntosh (1996) describe the link between the use of experientially gained knowledge and that of intuition in pre-decisional activity. This not only exerts a strong influence over the assessment of a person's actual health state but also has direct implications for goal setting.

Business processes which facilitated the movement from assessment to resource implementation appeared to influence needs-led assessment for all professional groups participating in the study although the particular influences differed slightly between health and social care staff. Resource availability, awareness, access, eligibility and authorisation all featured as key components which influenced the assessment of need either consciously or subconsciously. Social workers appeared to have more detailed knowledge of resources and their availability, access, funding and timescales: whilst this knowledge was resisted as an assessment influence, it often affected the needs and interventions identified. Nurses expressed less of an awareness of resource constraints but appreciated

the funding restrictions experienced by social services. This did not deter nurses from making referrals for resources they were not responsible for. The study did however suggest that despite concerns that nurses might hold unrealistic expectations and over-refer for services, both health and social work staff, when presented with additional resources, referred in relatively equal amounts. Nurse interviewees did express a sense of relief at being free of conscious resource restraints which in theory suggested they might be more needs-led in their approach, however they similarly expressed frustration at being at the mercy of other organisations who ultimately made the decision to access (or not) a service requested by health practitioners.

The issue of rationing was raised in several components as an influential factor and one which distinguished health from social work staff. Rationing or prioritising as it was often referred to in social work, involved the evaluation of client need against a multitude of factors including risk, level of need, waiting lists, alternative solutions, client and/or carer demand. In the majority of cases this occurred close to the client and was often undertaken by the assessor or in collaboration with the assessor's line manager. Rationing within health interviews was rarely mentioned: where needs were identified for clients, there was an expectation they would be met. The reality that both organisations were presented with limitless need amidst limited resources was often overlooked by health staff. This was explained by some interviewees with the fact that rationing in the health service occurred at a distance from the client and the practitioner. Most health professionals did not have to ration organisational time and resources between clients unlike their social work counterparts for whom this was an everyday occurrence.

Ultimately assessment outcomes varied little between professionals despite differences identified in the process, organisational structure, influential components, roles and responsibilities. Outcomes were mainly defined in terms of resources as opposed to states of being therefore given the limited lists of resources available, the opportunity for diversity of outcomes was controlled and finite. There was often general consensus

about the needs of clients: differences were identified in the routes taken and frustrations/influences experienced along the way.

Of interest was the tenacity with which members of the study sample referred to other professional groups. When questioned further, the majority of interviewees admitted understanding little about the roles and responsibilities of members of those professional groups despite making regular referrals and demands of their services. Similarly both health and social care staff considered themselves, in general, to be better placed to assess and manage the needs of the couple depicted in the vignette sequence. The reasons given for this were the same across professional groups with each believing themselves better equipped to deal with presenting needs. Only in a few interviews was the need and opportunity for interagency collaboration identified.

Collaboration between those involved in formal resource provision is an area of need highlighted in previous and recent community care legislation. This alongside increased user and carer participation in the assessment, planning, implementation and evaluation stages is considered a prerequisite in the search for seamless care. The NHS and Community Care Act (DoH 1990) reiterated the need to reduce fragmentation in service delivery,

“The objective must be to provide a service in which the boundaries between health care, secondary care and social care do not form barriers seen from the perspective of the service user. How this is done will reflect the way local and health authorities work together and organise their resources” (DoH 1990 pages 8–9)

Stalker (1993) emphasises the importance of information sharing at the planning stage yet highlights the strategic and operational difficulties which arise when inconsistencies exist between the main disciplines involved: ‘local authorities and health boards, are accountable to different masters and subject, therefore to differing demands and priorities’ (Stalker 1993 page 8). One area of contention identified by Higgins et al.

(1994) following an evaluation of a joint community care project based in Rothwell, was that of cultural differences which impact on operational aspects of care delivered by health or social care staff. Health staff were observed as operating within a medical model whereby professionals dealt with people's physical illnesses and interactions were considered tangible. Alternatively social services staff directed interventions towards underlying social and/or mental health problems which were perceived as being a more difficult and intangible task. Lightfoot (1995) highlights not only the gaps in provision between health and social care but also the overlap, and expresses the importance of practitioner harmony in addressing these areas. The impetus for such change particularly in relation to assessment of individual and community needs is exhorted in the White Paper, 'Caring for People' (1989),

"It is essential that the caring services should work effectively together, each recognising and respecting the others contributions and responsibilities [...] there is no room in community care for a narrow view of individuals' needs, nor of ways of meeting them" (DoH 1989 page 13 para 2.20)

Health and social care operate under fundamentally diverse financial structures: health care is free at the point of contact whilst social or community care is largely at a cost to the consumer, normally subject to means testing. Caldock (1994b), alluding to the differences perceived to exist between health and social services, argues that there is an apparent split not only in individual assessment and care provision, but that divisions were apparent at higher management levels too, including planning, training, and documentation of new procedures for change. The underlying misunderstanding of the roles, responsibilities and remits of other agencies, argues Caldock (1994b) have 'led to disputes over demarcations and boundaries in health and social care' (Caldock 1994b page 145).

### **10.3 Consideration of Study Results within Current Scottish, Political Climate**

During the study Single Shared Assessment was introduced in Scotland as a mechanism to improve inter-agency collaboration, reduce duplication between professionals and, produce quicker and more effective access to resources for clients in the community. The implementation of SSA meant that many interviewees had given significant thought to their particular, professional assessment, the ways in which disciplines differed in their approaches to assessment and, roles and responsibilities in the assessment / care management cycle. Needs-led assessment therefore remained topical throughout the course of the study and was critically examined by interviewees during the study. Policy surrounding SSA had led to Local Authorities and Health Boards working collaboratively to develop standardised assessment recording tools which were acceptable to health, social work and housing practitioners. Focus on assessment tools, in hindsight, detracted from the assessment practice surrounding its application. With a preoccupation on the format and content of assessment recording tools, practitioners displayed a predisposition to assess within the parameters of particular tools and models. In some cases assessors appeared to dispense of their professional experience and expertise within the field of community care for older people and limit assessments only to that which was asked of them. The notion of a good assessment being the product of a good assessor appeared undermined by the effort applied to getting the assessment tool right.

Focus on the assessment tool also led to other components of the assessment / care management cycle being neglected. Within Scotland much activity, centrally and locally, involved the assessment of need with little regard for other, equally as significant stages. Care planning, implementation, review and reassessment were neglected in favour of an all encompassing assessment tool. Only recently has policy in Scotland readjusted the balance with the publication of the Care Management Framework and the Report from the 21<sup>st</sup> Century Review of Social Work

(2006). With a reemphasis on better and quicker access to shared resources, standardised shareable assessment information, effective mechanisms of data sharing: each managed within a framework of integrated working (including shared values) the proposed success of SSA is now being realised.

Throughout the data collection and analysis stages of the study, the implications of SSA were apparent. The disadvantages and restrictions experienced as a result of an over-emphasis on the assessment without due consideration of the skills, experience and expertise applied to the process and subsequent assessment-related activity were paralleled with a preoccupation toward needs-led assessments regardless of post-assessment activity. An awareness of resources and associated influences appeared to provide a more balanced assessment of need when considered within an aspirational yet realistic assessment process.

#### **10.4 Consideration of Conclusions and Recommendations**

This chapter has examined the concept of needs-led assessment as it is considered in policy and applied in practice, including professional perspectives. The complexities of the principles associated with needs-led assessment, alongside the context of implementation within caring professions makes generalisations very difficult. In light of some of the apparent contradictions described, several causes and solutions have been volunteered.

Recognition of users and carers as consumers as not merely contributors to assessment procedures and resource allocation, demands radical reorganisation of thinking patterns. Several forms of documentation have been introduced in order to facilitate the transition from thinking to behaviour or perhaps vice versa. To ensure that new procedures do not simply become a paper exercise, Nolan and Caldock (1996) note the suggestion that assessment documentation which is too long and complex could be discarded, possibly in the favour of client-specific approaches.



Implications for resources: not only those related to service provision but also availability of assessors and the allocation of time must be considered. Investment in the assessor rather than the assessment may remove some bureaucratic obstacles but does present some idiosyncrasies of its own. Professional vulnerability to external and internal constraints may compromise objectivity, 'subjecting' users and carers to a process, which has little grounds for reliability. Possible solutions are: firstly the separation of assessment from care management: this would serve the multiple function of shielding time whilst developing specialised skills in the area of assessment. Meanwhile the influence of external restraints would be minimised (such as scarce resources, eligibility criteria, time restrictions). Removal of accountability and responsibility for service provision post-assessment may liberate some of the constraining pre-decisional activity already identified.

Secondly it is clear that values inherent to practice play a major role in fashioning attitudes towards assessment. Assessment is fundamental to the policy and practice of health and social care and as such is given great emphasis in training and education. Values fashioned during training could precipitate and militate against the culture of change which typifies the world of health and social care.

Nolan and Caldock (1996) assert that at conceptual and inter-professional level, there is a need for a more precise and shared definition of how to achieve a 'needs-led assessment. At interprofessional level solutions have been suggested in terms of assessment, care and joint training initiatives. Training curriculum designed to accommodate changing patterns of practice and allow development of good assessment skills will contribute to community care implementation criteria (Boyce 1996, Runciman 1989, Torkington et al. 2004, Keene et al. 2001). Finally concurrent development of an assessment procedure or protocol the design of which is: comprehensive to discourage narrow mindedness; holistic to avoid territorialism; objective to dispel managerialist tendencies; and acceptable to users, carers and assessors alike, will help the assessor

function independently and efficiently in the new needs-led culture (McWalter et al. 1994).

### **10.5 Questions Raised but Unanswered by the Study**

The study explored in great detail the factors influential in decision-making by professionals which included their perception of client and carer perspectives. The models adhered to by professional groups were fiercely defended as were the rights, preferences, needs, risks and self-determination of clients. As already identified, this sentiment was expressed more strongly by social work staff who appeared to consider the citizen centric approach more favourably. With respect to the process and outcome of assessment the study would be enhanced by further questioning about the professional's perception of the client's perspective and the potential change to outcomes that might produce. The study failed to determine distinctly whether it mattered which professional group undertook a needs-led assessment: this presumably would be based upon the perceived benefits of a needs-led assessment by clients and the professional's ability to accomplish that. Few interviewees considered the benefits to the client of a needs-led assessment within the reality of resource restricted organisations.

Rarely did interviewees question the propriety of needs-led assessment as a principle. The practical realities presented immense pressures, yet few interviewees questioned the underpinning principles. The majority of respondents endeavoured to undertake needs-led assessment at the expense of factors such as personal time, energy, popularity, conflicting demands. No-one questioned the legality or the fairness to the client, carer or professional of needs-led assessment but accepted its application as good practice. Few benefits were identified as most discussions featuring needs-led assessment as a principle of good practice, failed to translate the policy imperatives into practical realities.

Interviewees, particularly within social work did raise the conflicts which emerged when presented with the dual role as needs-led assessor and

gatekeeper to limited resources. Within the context of demanding caseloads this raised moral and ethical dilemmas for professionals which were only explored superficially within the confines of the study. Some questioned the sustainability of this role but few offered alternative suggestions to the management of needs-led assessment and resource management.

No-one questioned the legal basis for identifying unmet and unmeetable need: indeed no-one offered a distinction between the two. Concerns were raised about litigation and the presentation of false hope to clients and carers, but in policy terms, no interviewees questioned the legality of needs-led assessment within resource constrained organisations. Had interview time allowed, the author would have explored this area further.

## **10.6 Critical Reflections from the Study**

The study provided the author unique insight into the minds of assessors as they endeavoured to assess and address the needs of clients. A particular highlight of the study was the frequent episodes when behaviours, previously subconsciously demonstrated by professionals, became a conscious awareness. For instance identification of factors influencing the extent to which needs were assessed and addressed were often expressed with a level of surprise: interviewees were rarely consciously aware of influencing factors until they began to describe these during the interview. The extent to which these influences or pressures shaped the assessment of need was often underestimated by the interviewee at the beginning of the interview, however during the course of the discussion these factors became more critical to the assessment of need and actions taken. Many interviewees expressed the fact that they were rarely afforded the opportunity to reflect on practice. Most identified the study interview as a luxury: that they enjoyed the experience and would be interested to read the results on completion.

The recruitment phase of the study proved difficult for certain professional groups, in particular GPs. Much time was spent trying to engage GPs and

practice managers however uptake remained extremely poor. It is the author's opinion that the study would be enhanced with more GP representation however this proved almost impossible and efforts were abandoned and concentrated on other professional groups. However a recognised strength of the study was the wide selection of staff groups and the cross section of North Glasgow represented. This allowed a range of comparisons to be made.

On reflection, the author considered questions and processes critical to the study. The research area chosen not only remained topical, but over time grew in importance as policy in Scotland developed. The introduction of the concept of SSA in 2000 brought with it a renewed emphasis on the assessment process, principles of good practice, an awareness of professional, cultural elements and shared roles and responsibilities within health and social care in the community. For this reason, it is the author's opinion that interviewees engaged more readily in the debate about needs-led assessment and its implications for practice. Alternative research methodologies were also considered: a critical analysis of the use of sequenced vignettes and the responses they produced reassured the author that they were indeed an appropriate medium through which to engage professionals, standardise and stage information, direct discussion and consistently produce appropriate responses. The author was therefore convinced that vignettes were both valid and reliable mechanisms of eliciting value-based response to broad concepts. Alternative types of research methodology lacked the ability to control the variables presented to respondents and the method of delivery i.e. semi-structured questionnaires, allowed exploration of key themes as they emerged. The author conducted and transcribed all interviews personally, which provided an invaluable source of learning about: the research topic, how need and assessment were conceptualised in practice, how practitioners responded to practice-based research and effective methods to extract research information.

The author's understanding of the research topic as it was operationalised in practice grew exponentially throughout the study period: this

experience was applied during subsequent interviews as skills were honed.

During the course of data collection, the author continually re-evaluated the main research questions and their application in practice. Needs-led assessment appeared the epitome of good practice however, the reality of implementation amidst differing models of assessment and the influences of resource constraints, client and carer non-concurrence and concerns over risk did leave the author with a degree of doubt about the feasibility of practitioners applying these principles whilst maintaining their professional integrity to their assessment models, organisational values and professional priorities. Inherent contradictions appeared to present practice-based barriers to the implementation of a purist approach to needs-led assessment within resource constrained organisations. Internal and external influences seemed inevitable and the resultant consequences included assessments based upon resource availability and accessibility. A distinct lack of care planning as a separate entity also dissuaded the practice of needs-led assessment. The study indicated that few practitioners considered care planning as the interim stage between assessment and the implementation of interventions.

One of the key findings from the study was the all-encompassing nature of assessment within health and social care: needs were identified, interventions determined and resources accessed under the umbrella term 'assessment'. This was not a finding anticipated by the author therefore it appeared all the more poignant when persistently identified across professional groups. Similarly the unquestioned 'correctness' of needs-led assessment was considered upon reflection by the author. Taken from the perspective of the service user, studies suggested that ensuring deliverable outcomes proved more important than adhering to a particular approach to assessment (particularly when that approach might raise expectations which could not be met). This led the author to consider, 'does needs-led assessment make a difference to the journey of care as experienced by the client and their carer/s?' In the absence of a separate study examining this component, it was the author's suspicion

that access to resources mattered more to clients and practitioners than the process of needs identification and resource justification.

During the research period Local Authorities and Health Boards within Scotland were developing and implementing Single Shared Assessment tools and processes. Meanwhile the Scottish Executive was drafting guidance and minimum information standards to support the delivery of standardised, shareable assessment information. The author was able to contribute locally and nationally to these developments as a consequence of the knowledge gained through the research experience. It is the author's opinion that understanding of both the subject matter and the research process, as a direct result of the experience of undertaking a PhD, develops a particular formality of thinking which is reflective, analytical, structured, non-judgemental and holistic. This way of thinking has proven invaluable in subsequent research-related activities.

### **10.7 Recommendations if Study was repeated**

If repeated, several factors should be considered in conjunction with the data already collected. The study focuses on a professional perspective of need and outcomes. Given the importance expressed by many of those interviewed about the client and carer perspective of need, it would be beneficial to include service users and carers within the study sample. Identification of their perception of the situation: the needs identified, methods of assessment and actions taken, would provide a useful insight into professional and non-professional perspectives of needs-led assessment. This would provide a healthy balance for comparison.

Within any organisation change is a constant certainty. One disappointment experienced by the author was the length of time over which data was collected. If repeated, interviews would be undertaken within a relatively short period of time to minimise the effects of organisational change.

The importance of the assessment recording tool was indicated by several respondents. In the course of the study new needs assessment tools were being considered and latterly introduced. The impact this has on the practice of needs-led assessment cannot be ignored. This might be explored more explicitly by including an additional question such as,

“To what extent does the assessment tool determine the assessment of need?”

One benefit of this concurrent activity was the fact that organisational scrutiny of needs assessment tools and practice encouraged study participants to consider the opportunities and inhibitors afforded by existing and proposed needs assessment tools. Attention was already being directed toward professional perspectives of need and needs assessment therefore consideration during the study interview allowed expression or further discussion about personal views.

The extent to which organisational culture and values impacted on the assessment of need was identified during the study; however study questions did not explicitly consider and address this within the semi-structured questionnaire. The importance of organisational values and trends cannot be underestimated; therefore repetition of the study would be enhanced with more specific consideration given to the role and influences exerted by organisational values upon professionals as they undertake an assessment of need.

Questions such as: *“To what extent does professional culture & organisational values determine practice?”* and/or *“To what extent does professional training determine professional or organisational culture and values?”* might begin to explore these themes further. A more careful, considered exploration of perceived underpinning principles of the organisation within which people operate, and consideration of the perceived differences (if any) between organisations and disciplines would enhance the study by describing the organisational framework upon which professional practice is structured.

Study methodology was designed following a rigorous and comprehensive process: the vignette approach appeared to elicit the responses required and initiate further discussion on complex matters. The factors identified as influential in the identification of need and the ways in which it was addressed proved to be wide ranging. Repetition of the study would benefit from a narrower focus on particular key areas and their impact on decision-making as applied to needs-led assessment. Elements such as awareness of resource availability or funding could form a more targeted discussion, facilitating exploration of the extent to which specific components impacted upon an assessor's ability to be needs led.

The use of sequenced vignettes within the study facilitated the engagement of professionals into a theoretical yet realistic assessment of a client and their carer. In some circumstances however presentation of the second vignette led to repetition of issues raised with the first, and sometimes distracted the interviewee from pursuing thoughts and themes which were emerging. Whilst the author used discretion in progressing the emerging themes, the use of sequenced vignettes did not always appear necessary: the same insights, themes, issues may have been elicited through the use of just one vignette.

The value added by using sequenced vignettes can be considered in terms of: realistic progression of presentation of information, evidence of the assessment process as would occur over a period of time, an opportunity for professionals to reflect on situational variables and their impact on their assessment and, a useful method of easing interviewees into theorising their assessment practice. The drawbacks of using the sequenced vignettes included: the extended use of interview time, potential distraction and interruption of thought flows and the risk of boring interviewees with details which were potentially superfluous to the discussion of underpinning thoughts, influences and actions. If repeated, the study would benefit from the addition of a short, comparative pilot using just one vignette. This would help evidence the benefits or highlight the drawbacks of using sequenced vignettes for this type of investigation.



Analysis of vignette results using NVIVO proved helpful in constructing main themes as they emerged from the pilot and through the course of the main study. One drawback was the many sub-categories identified by interviewees, which caused the node structure to become overly complicated: this was translated into detailed analysis. If repeated, categories or nodes would be kept more general and the author would resist the temptation to include related themes as sub-headings within the tree node structure.

With respect to study questions and the methodology utilised to elicit appropriate responses, the approach taken produced a wealth of information which addressed the main study questions but also raised supplementary questions in the minds of participants and the author. The need to ensure the research interview was maintained within the restricted parameters of the semi-structured questionnaire would ensure that only completely relevant information was received and available for analysis. Whilst the wealth of information received during the study gave valuable insights into the decision-making activities of professionals, the parameters at times became too general and this was reflected during the analysis stage. If repeated questions would be minimised and focussed on certain predetermined topics.

### **10.8 Recommendations from Study Results**

The study highlighted several areas of contention for professionals and organisations and illustrated the difficulties experienced introducing a concept such as needs-led assessment into practice. Lessons were learned by the author and have since been applied to personal practice and, where opportunities arose, shared with colleagues, audiences and readers.

The requirement to create a degree of distance between the assessment and the care planning process became evident particularly when the results of combining the two were described by interviewees. Separate

protocols, business processes, paperwork would all enhance the professional's ability to make the mental separation between needs identified and resource requirements. It would also enhance the ability to record separately those needs which could not be met within existing resource availability.

The specialist skills identified in relation to professional assessors highlighted the requirement to ensure that these are maintained and developed pre and post professional registration. The opportunity to share assessment skills, models, experience and expertise also presented an opportunity which could be harnessed to the benefit of clients, professionals and organisations. This would also assist in the sharing of professional and organisational values and extend understanding of why professionals behave in particular ways. Joint training would also facilitate this process and enhance the skills required not only to assess but also to undertake the role of care manager.

The need and benefits of including service users and carers within the study sample has already been identified however, if repeated they would constitute a significant proportion of the study sample. Their responses would also be included in the pilot phase which may well affect the study methodology and approach.

Finally, if repeated the study literature review would consider the legal basis for identifying and recording unmet need. Since the study was conducted, several court cases have received a high profile whereby unmeetable needs were identified for clients which resulted in the professional organisation being sued for failure to adequately address needs. Having considered the literature surrounding the courts' decisions, further consideration of the policy basis and legal framework upon which needs-led assessment is supported is required. The detail this would produce may well change the direction of the study questions and responses.

## REFERENCES

- Adair, J. G. (1984) The Hawthorne effect: a reconsideration of the methodological artefact. *Journal of Applied Psychology*. 69 (2), 334 - 345
- Adair, J. G., Sharpe, D. and Huynh C. L. (1989) Hawthorne control procedures in educational experiments: a reconsideration of their use and effectiveness. *Review of Educational Research*. 59 (2), 215 - 228
- Alexander, C. S. and Becker, H. J. (1978) The use of vignettes in survey research. *Public Opinion Quarterly*. 42, 93 - 104
- Allen, I., Hogg, D. and Peace, S. (1992) *Elderly People: Choice, Participation and Satisfaction*. Policy Studies Institute. London
- Allott, M. and Robb, M. (Editors) (2006) *Understanding Health and Social Care: an Introductory Reader*. Sage Publication, London, Thousand Oaks
- Arnstein, S. (1969) A ladder of citizen participation. *Journal of the American Institute of Planners*. 35, 214 - 224
- Badger, F., Cameron, E., Evers, F. and Griffiths, R. (1988) Nursing in Perspective. *Health Service Journal*. 17 Nov, 1362 - 1363
- Balacki, M. F. (1988) Assessing mental health needs in the rural community: a critique of assessment approaches. *Issues in Mental Health Nursing*. 9, 299 - 315
- Baldock, J. (1993) Participation in home based care. *Innovation and participation in care of the elderly*. Italy meets Europe. International Conference, Rome 20 - 22
- Baldwin, S. and Woods, P. A. (1994) Case management and needs assessment: some issues of concern for the caring professions. *Journal of Mental Health*. 3, 311 - 322

Barnes, D. M. (1996) An analysis of grounded theory method and the concept of culture. *Qualitative Health Research*. August 6 (3), 429 – 441

Barnes, M., Matka, E. and Sullivan, H. (2003) Evidence, understanding and complexity: evaluation of non-linear systems. *Evaluation*. 9 (3), 263 - 282

Barr, O. (1996) A consideration of the nature of “needs – led service” within care management in the UK. *Online Journal of Issues in Nursing*. June 15, [http://www.nursingworld.org/ojin/tpc2\\_I.htm](http://www.nursingworld.org/ojin/tpc2_I.htm)

Bath, P., Philp, I., Boydell, L., McCormack, W., Bray, J. and Roberts, H. (2000) Standardized health check data from community – dwelling elderly people: the potential for comparing populations and estimating need. *Health and Social Care in the Community*. 8 (1), 17 - 21

Beck, C. T. (1993) Qualitative research: the evaluation of its credibility, fittingness, and auditability. *Western Journal of Nursing Research*. 15 (2), 263 – 266

Bell, I. (1993) Less impertinence, more partnership. *Health Visitor*. 66 (10), 370 - 372

Bellman, L. M. (1996) Changing nursing practice through reflection on Roper, Logan and Tierney Model: the enhancement approach to action research. *Journal of Advanced Nursing*. 24, 129 - 138

Benbenishity, R. (1992) An overview of methods to elicit and model expert clinical judgement and decision-making. *Social Service Review*. December, 598 - 616

Bennet, H.E., Wood, C. L. and Hare, D. J. (2005) Providing care for adults with autistic spectrum disorders in learning disability services: needs – based or diagnosis-driven? *Journal of Applied Research in Intellectual Disabilities*. 18, 57 – 64

Bensen, K. and Hatrz, A. J. (2000) A comparison of observational studies and randomized controlled trials. *The New England Journal of Medicine*. 342 (25), 1878 – 1886

Beresford, P. and Croft, S. (1993) *Getting Involved: A Practical Manual*. Open Services Project. London

Berkman, B., Chauncy, S., Holmes, W., Daniels, A., Bonander, E., Sampson, S. and Robinson, M. (1999) Standardized screening of elderly patients' needs for social work assessment in primary care: use of the SF – 36. *Health and Social Work*. 24 (1), 9 -16

Billings, J. R. and Cowley, S. (1995) Approaches to community need assessment: a literature review. *Journal of Advanced Nursing*. 22 (4), 721 – 730

Bonuck, K.A. (1996) Theory and method: a social work approach to unmet needs. *Administration in Social Work*. 20 (2), 29 - 40

Boyce A (1996) Effective training begins with needs assessment. *Occupational Health and Safety*. 65 (8), 72 – 73

Bradley, G. and Manthorpe, J. (1993) The dilemmas of financial assessment: professional and ethical difficulties. *Practice*. 7 (4), 21 - 30

Bradshaw, J. (1972) The concept of social need. *New Society*. 30, 640-643

Brewin, C. (1992) Measuring individual needs for care and services. In G. Thornicroft, C. Brewin and J. Wing (Editors). *Measuring Mental Health Needs* London, Royal College of Psychiatrists

Brewin, C. R., Wing J. K., Mangen, S. P., Brugha, T. S. and MacCarthy B. (1987) Principles and practice of measuring needs in the long-term

mentally ill: the MRC needs for care assessment. *Psychological Medicine*. 17, 971-981

Briggs, S. (1991) Community care, case management and the psychodynamic perspective. *Journal of Social Work Practice*. 5, 71 - 81

Bryans, A. and McIntosh, J. (1996) Decision-making in community nursing: an analysis of the stages of decision-making as they relate to community nursing assessment practice. *Journal of Advanced Nursing*. 24, 24 - 30

Bryans, A. N. (2004) Examining health visiting expertise: combining simulation, interview and observation. *Journal of Advanced Nursing*. 47 (6), 623 - 630

Bryans, A. N. and McIntosh, J. (2000) The use of simulation and post - simulation interview to examine the knowledge involved in community nursing assessment practice. *Journal of Advanced Nursing*. 31 (5), 1244 - 1251

Cairns, J. (1996) Measuring health outcomes: condition specific and patient specific measures are of limited use when allocating resources. *British Medical Journal*. 313, 6

Caldock, K. (1993) A preliminary study of changes in assessment: examining the relationship between recent policy and practitioners' knowledge, opinions and practice. *Health and Social Care in the Community*. 1, 139 - 146

Caldock, K. (1994a) Policy and practice: fundamental contradictions in the conceptualisation of community care for elderly people? *Health and Social Care in the Community*. 2, 133 - 141

Caldock, K. (1994b) The new assessment: moving towards holism or new roads to fragmentation? In, *Community Care: New Agendas and*

*Challenges from the UK and Overseas*. Challis, D., Davies, B, Traske, K. (Editors), BSG/PSSRU Arena, Ashgate Publishing, Aldershot, 133 – 148

Caldock, K. (1995) Unmet need in social care: a tale of confusion? *Generations Review*. 5 (4), 2 - 2

Caldock, K. (1996) Multi - disciplinary assessment and care management. In Phillips, J., Penhale, B (Editors). *Reviewing Care Management for Older People*. London, Jessica Kingsley

Caldock, K. and Nolan, M. (1994) Assessment and community care: are the reforms working? *Generations Review: Journal of the British Society of Gerontology*. 4, 3, November

Carris-Verhallen, W., Kerkstra, A. and Jozien, M. (1997). The role of communication in nursing for elderly people: a review of the literature. *Journal of Advanced Nursing*. 25 (5), 915 - 933.

Carroll, J. S. and Johnson, E. J. (1990) *Decision Research: A Field Guide*. Sage Publications. Newbury Park. California

Carter, M.F., Crosby, C., Geerthuis, S. and Startup, M. (1995) A client - centred assessment of need needs assessment. *Journal of Mental Health*. 4, 383 - 394

Cavanagh, S. (1997) Content analysis: concepts, methods and applications. *Nurse Researcher*. 4 (3), 5 - 16

Challis, D., Weiner, K., Darton, R., Hughes, J. and Stewart, K. (2001) Emerging patterns of care management: arrangements for older people in England. *Social Policy and Administration*. 35 (6), 672 – 687

Clarke, D. (1990) Nursing: a problem-solving or a needs-meeting activity? *Senior Nurse*. 10 (2), 13 – 14

Concato, J. Shah, N. and Horwitz, R. I. (2000) Randomized, controlled trials, observational studies, and their hierarchy of research decisions. *The New England Journal of Medicine*. 342 (25), 1887 - 1892

Cook, T. D. and Campbell, D. T. (1979) *Quasi - Experimentation: Design and Analysis for Field Settings*. Rand McNally, Chicago, Illinois

Cornwell, N. (1992) Assessment and accountability in community care. *Critical Social Policy*. 306 (4052), 40 - 52

Cowley, S. and Houston, A.M. (2003) A structured health needs assessment tool: acceptability and effectiveness for health visiting. *Journal of Advanced Nursing*. 43 (1), 82 - 92

Cowley, S., Bergen, A., Young, K. and Kavanagh, A. (1996) Establishing a framework for research: the example of needs assessment. *Journal of Clinical Nursing*. 5, 53 - 61

Creswell, J. W. (1994) *Research design: qualitative and quantitative approaches*. Sage Publications. Thousand Oaks, London

Crome, P. and Phillipson, C. (2000) Editorial: Assessment of need. *Age and Ageing*. 29 (6), 479 - 480

Culyer, A. J. (1995) Editorial. Need: the idea won't go away - but we still need it. *Social Science and Medicine*. 40 (6), 727 - 730

Culyer, A., J. (1976) *Need and the National Health Service*. York Studies in Economics. Martin Robertson, London

Curnock, K. and Hardiker, P. (1979) *Towards Practice Theory: Skills and Methods in Social Assessments*. Routledge and Kegan Paul. London

Currer, C. and Stacey, M. (1986) *Concepts of health, illness and disease: a comparative perspective*. Leamington Spa. Berg



Davies, B. (1977) Needs and outputs. In H. Heisler (Editor) *Foundations of Social Administration*. Macmillan. London

Davies, B. and Challis, D. (1986) *Matching resources to needs in community care: an evaluated demonstration of a long-term care model*. Gower Publishing Company Limited, Hants

DoH (1990) *The National Health Service and Community Care Act*. HMSO, London

DoH (1993a) *Implementing Community Care. Population Needs Assessment: Good Practice Guidance*. HMSO. London

DoH (1993b) Monitoring and development: assessment special study. Joint SS1/NHSME. *Study of Assessment Pointers in Five Local Authority Areas*. DoH, London

DoH (1995) *Carers (Recognition and Services) Act: Policy Guidance and Practice Guide*. HMSO. London

DoH/SSI and Social Work Services Group. (1991a) *Care management and assessment: practitioners' guide*. HMSO

DoH/SSI and Social Work Services Group. (1991b) *Care management and assessment: managers' guide*. HMSO

DoH/SSI (1993) *Empowerment, assessment, care management and the skilled worker*. HMSO. London

DoH and Social Security (1942) *The Beveridge Report*. HMSO. London

DoH and Social Security, and the Welsh Office. (1989) *Caring for people: community care in the next decade and beyond*. HMSO

Donabedian, A. (1973) *Aspects of Medical Care Administration*. Cambridge, Mass. Harvard University Press

Doyal, L. and Gough, I. (1991) *A theory of human need*. The MacMillan Press Limited, London.

Ellis, K. (1993) *Squaring the Circle: User and Carer Participation in Needs Assessment*. Joseph Rowntree Foundation, York.

Endacott, R. (1994) Objectivity in observation. *Nurse Researcher*. 2 (2), 30 - 40

Endacott, R. (1997) Clarifying the concept of need: a comparison of two approaches to concept analysis. *Journal of Advanced Nursing*. 25 (3), 471 - 476

Fagermoen, M. S. (1997) Professional identity: values embedded in meaningful nursing practice. *Journal of Advanced Nursing*. 25 (3), 434 - 441

Fagnani, F. and Dumenil, G. (1976) Health indicators or health system analysis? Extracts from a French survey. *Soc. Indicators Res. (list title in full)* 3, 37 - 74

Falloon, I. R. H. and Marshall, G. N. (1983) Residential care and social behaviour: a study of rehabilitation needs. *Psychological Medicine*. 13, 341 - 347

Farrell, G. (1991) How accurately do nurses perceive patients' needs? A comparison of general and psychiatric settings. *Journal of Advanced Nursing*. 16, 1062 - 1070

Finch, J. (1987) Research note: the vignette technique in survey research. *Sociology*. 21 (1), 105 - 114

Flauskerud, J. H. (1979) Use of vignettes to elicit responses toward broad concepts. *Nursing Research*. 28, 210 – 212

Fox, S. and Dingwall, R. (1985) An exploratory study of variations in social workers' and health visitors' definitions of child mistreatment. *British Journal of Social Work*. 15, 467 – 477

Futter, C. and Penhale, B. (1996) Needs-led Assessment: the Practitioner's Perspective. In J Phillips and B Penhale (eds) *Reviewing Care Management for Older People*. London: Jessica Kingsley, Chapter 4

Gambrill, E. and Gibbs, L. (2002) Making practice decisions: is what's good for the goose good for the gander? *Ethical Human Sciences and Services*. 4 (1), 31 – 46

Glasby, J. (2003) Bringing down the 'Berlin Wall': the health and social care divide. *British Journal of Social Work*. 33 (7), 969 – 975

Gomm, R., Hagen, A. C., Rudge, D. and Smith, R. (1993) Whose need is it anyway? A care management project in Cheltenham. In Smith, R., Gaster, L., Harrison, L., Martin, L, Means, R., Thistlethwaite, P (Editors) *Working Together for Better Community Care*. Bristol, SAUS. 83 – 112

Gordon, D. and Spicker, P. (1997) Chapter 3: Demography, Needs and Planning: the Challenges of a Changing Population. In *Dementia – Challenges and New Directions*. Jessica Kingsley Publishers. Edited by Susan Hunter. 42 – 67

Gould, D. (1996) Using vignettes to collect data for nursing research studies: how valid are the findings? *Journal of Clinical Nursing*. 5, 207 - 212

Green, M. (2004) Down on your needs. *Health Service Journal*. 20 May, [www.hsj.co.uk](http://www.hsj.co.uk)

Griffiths, J., M. and Luker, K. A. (1994) Intraprofessional teamwork in district nursing: in whose interest? *Journal of Advanced Nursing*. 20, 1038 – 1045

Griffiths, R. (1988). *Community Care: Agenda for Action*. HMSO, London

Hakim, C. (1994) *Research Design: strategies and choices in the design of social research*. London, Routledge

Hamid, W.A., Howard, R. and Silverman, M. (1995) Editorial Comment: Needs assessment in old age psychiatry – a need for standardisation. *International Journal of Geriatric Psychiatry*. 10, 553 – 540

Hardina, D. (2005) Ten characteristics of empowerment-oriented social service organisations. *Administration in Social Work*, 29 (3), 23 - 42

Harding, K., Baldwin, S. and Baser, C. (1987) Towards multi-level needs assessment. *Behavioural Psychotherapy*. 15, 134 – 143

Harris, J. (1999) State social work and social citizenship in Britain: from clientelism to consumerism. *British Journal of Social Work*. 29 (6), 915 - 936

Hasenfield, Y. (1992) Power in social work practice. In Y. Hasenfield (Editor) *Human Services as Complex Organisations*. Sage Publications. London

Hawkins, L., Fooke, J. and Ryan, M. (2001) Social workers' use of the language of social justice. *British Journal of Social Work*. 31 (1), 1 – 13

Haywood, S. and Alaszewski, A. (1980) *Crisis in the Health Service*. London. Croom Helm

Healy, T. (2003) Ethical decision-making: pressure and uncertainty as complicating factors. *Health and Social Work*. 28 (4), 293 – 301

Healy, K. and Meagher, G. (2004) The reprofessionalization of social work: collaborative approaches for achieving professional recognition. *British Journal of Social Work*. 34 (2), 243 – 260

Henriksen, E. and Rosenqvist, U. (2003) Contradictions in elderly care: a descriptive study of politicians' and managers' understanding of elderly care. *Health and Social Care in the Community*. 11 (1), 27 – 35

Hewison, A. (1996) Organizational culture: a useful concept for nurse managers? *Journal of Nursing Management*. 4 (1), 3 – 9

Higgins, R., Oldman, C., Hunter, D. J. (1994) Working together: lessons learned for collaboration between health and social services. *Health and Social Care in the Community*. 2, 269 – 277

Holland, W. W. (1983) Concepts and meaning in evaluation of health care. In W. W. Holland (Editor) *Evaluation of Health Care*. Oxford University Press. Oxford

Hostick, T. (1995) Research design and methodology for a local mental health needs assessment. *Journal of Psychiatric and Mental Health Nursing*. 2, 295 – 299

Howe, A. (2003) How to research how we decide? *Medical Education*. 37, 762 – 763

Hudson, B. (1999) Joint commissioning across the primary health care – social care boundary: can it work? *Health and Social Care in the Community*. 7 (5), 358 – 366

Hughes, B. (1995) *Older People and Community Care: critical theory and practice*. Open University Press

Hughes, R. and Huby, M. (2004) The construction and interpretation of vignettes in social research. *Social Work and Social Sciences Review*. 11

(1), 36 – 51

Hunter, D. (1988) Meeting the challenge of co-ordinated service delivery. In B. Gearing, M. Johnson and T. Heller (Editors.) *Mental Health Problems in Old Age*. J. Wiley and sons. Chichester

Illich, I. (1976) *Limits to Medicine. Medical Nemesis: The Expropriation of Health*. Penguin Books London

International Association of Schools of Social Work (2001). International Definition of Social Work, online at <http://www.iassw-aiets.org/>

Jones, K., Brown, J. and Bradshaw, J. (1983) *Issues in Social Policy*. Revised Edition, Routledge and Kegan Paul, London

Jordan J, and Wright, J. (1997) Editorial: Making sense of health needs assessment. *British Journal of General Practice*. November, 695 – 696

Junnola, T., Eriksson, E., Salanterä, S. and Lauri, S. (2002) Nurses' decision-making in collecting information for the assessment of patients' nursing problems. *Journal of Clinical Nursing*. 11, 186 – 196

Keene, J., Swift, L., Bailey, S. and Janacek, G. (2001) Shared patients: multiple health and social care contact. *Health and Social Care in the Community*. 9 (4), 205 – 214

Kempshall, H. (1986) Defining client's needs in social work. *Social Work Monographs*. Norwich, UEA

Kennedy, C.M. (2004) A typology of knowledge for district nursing assessment practice. *Journal of Advanced Nursing*. 45 (4), 401 – 409

Knox, E. G. (1978) Principles of allocation of health care resources. *Journal of Epidemiology and Community Health*. 32, 3 - 9

Koch, T. (1994) Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing*. 19, 976 – 986

Kreidler, M. C., and Conrad, M. A. (1992) A study of client's perceived needs in a nursing center. *Journal of Nursing Care Quality*. 7 (1), 57 – 63

Lanza, M. L. (1988) Technical notes: development of a vignette - a data collection instrument about patient assault. *Western Journal of Nursing Research*. 10 (3), 346 – 351

Lanza, M. L. (1990) A methodological approach to enhance external validity in simulation based research. *Issues in Mental Health Nursing*. 11, 407 – 422

Lasalvia, A., Ruggeri, M., Angela, M. and Dall'Agnola, R.B. (2000) The perceptions of needs for care in staff and patients in community-based mental health services. The South Verona Outcome Project 3. *Acta Psychiatrica Scandinavica*. 102 (5), 366 - 375

Lemmer, B. (1998) Successive surveys of an expert panel: research in decision-making with health visitors. *Journal of Advanced Nursing*. 27, 538 – 545

Lightfoot, J. (1995) Identifying needs and setting priorities: issues of theory, policy and practice. *Health and Social Care in the Community*. 3, 105 – 111

Little, M., Bullock, R., Madge, J. and Arruabarrena, I. (2002) How to develop needs – led, evidence – based services. *MCC: Building Knowledge for Integrated Care*. 10 (3), June, 28 -31

Lloyd, P. (1991) The empowerment of elderly people. *Journal of Ageing Studies*. 5, 125 – 135

Lloyd, M. (2000) Where has all the care management gone? The challenge of Parkinson's disease to the health and social care interface. *British Journal of Social Work*. 30 (6), 737 - 754

Magi, M. and Allander, E. (1981) Towards a theory of perceived and medically defined need. *Sociology of Health and Illness*. 3 (1), 49 - 71

Marshall, M. T. (1990) *Social Work with Old People*. (Second Edition) MacMillan. London

Maslow, A. (1968) *Toward a Psychology of Being*. Second Edition. New York, Van Nostrand

Maynard, A. (1990) The ethics of resource allocation: proceedings of a symposium held at the University of Manchester during the 33rd Annual Scientific Meeting of the Society for Medicine September 1989. *Journal of Epidemiology and community Health*. 44, 187 - 190

McCutcheon, J. and Pincombe, J. (2001) Intuition: an important role in the practice of nursing. *Journal of Advanced Nursing*. 35 (3), 342 - 348

McIntosh, J., Moriarty, D., Lugton, J. and Carney, O. (2000) Evolutionary change in the use of skills within the district nursing teams: a study in two Health Board Areas in Scotland. *Journal of Advanced Nursing*. 32 (4), 783 - 790

McWalter, G (1997) What do we mean when we talk about assessment? In M. Marshall (Editor). *State of the Art in Dementia Care*. London, Centre for Policy on Ageing

McWalter, G., Toner, H., Corser, A., Eastwood, J., Marshall, M. and Turvey, T. (1994) Needs and needs assessment: their components and definitions with reference to dementia. *Health and Social Care*. 2, 213 - 219



McWalter, G., Toner, H., McWalter, A., Eastwood, J., Marshall, M. and Turvey, T. (1998) A community needs assessment: the Care Needs Assessment Pack for Dementia (Carenap-D) – It's development, reliability and validity. *International Journal of Geriatric Psychiatry*. 13, 16 – 22

Meeks, J. B. (2001) A social work case management experience in a managed care setting: the need for effective communication. *Home Health Care Management and Practice*. 13 (6), 444 – 451

Meethan, K. and Thompson, C. (1993) *In their own homes: incorporating carers' and users' views in care management*. Social Policy Research Unit. York

Meyer, C. H. (1993) *Assessment in social work practice*. New York. Columbia University Press

Middleton, L. (1994) Little Boxes are not enough. *Care Weekly*. 20 January, 10 - 11

Miller, D. (1976) *Social Justice*. Oxford University Press, Oxford

Miller, G. and Dingwall, R. (1997) *Context and method in qualitative research*. Sage Publications, Thousand Oaks, London

Morrison, E.G. (1989) Nursing assessment: what do nurses want to know? *Western Journal of Nursing Research*. 11 (4), 469 - 476

Muir, N. (2004) Clinical decision-making: theory and practice. *Nursing Standard*. 18 (36), 47 – 52

Myers, F. and MacDonald, C. (1996) Power to the people? Involving users and carers in needs assessments and care planning – views from the practitioner. *Health and Social Care in the Community*. 4 (2), 86 - 95

National Health Services Management Executive (1991) *Assessing Health*

*Care Needs: a DHA Project Discussion Paper*. NHSME. London

Neeraj, K., Ayanian, J. Z. and Guadagnoli, E. (2005) Examining the relationship of patients' attitudes and beliefs with their self reported level of participation in medical decision-making. *Medical Care*. 43 (9), 865 – 872

Nolan, M. (1994) Geriatric nursing: an idea whose time has gone? A polemic. *Journal of Advanced Nursing*. 20, 989 - 996

Nolan, M. (2000) Skills for the future humanity of caring (lecture). *Nursing Management*. 7 (6), 22 – 29

Nolan, M. and Caldock, K. (1996) Assessment: identifying the barriers to good practice. *Health and Social Care in the Community*. 4 (2), 77 – 85

Nolan, M., Grant, G., Caldock, K. and Keady, J. (1994) A framework for assessing the needs of family carers: a multidisciplinary guide. BASE Publications. Stoke on Trent

Norman, A. (1984) Word play. *New Age*. 24, 29

Ong, B. N. (1991) Researching needs in district nursing. *Journal of Advanced Nursing*. 16, 638 - 647

Ong, B. N. (1995) Multi-dimensional measurement of need and outcome in physical disability. *Journal of Interprofessional Care*. 9 (3), 275 - 287

Orr, J. (1983) Is health Visiting meeting today's needs? *Health Visitor*. 56 (6), 200 - 203

Parker, G. (2000) *Access to social care for older people: literature review*. University of Leicester, Nuffield Community Care Studies Unit.

Parker, G. (2002) Guest editorial: 10 years of the 'new' community care: good in parts? *Health and Social Care in the Community*. 10 (1), 1 - 5

- Parrott, L. (2002) *Social work and social care*. Routledge, London
- Parry – Jones, B. and Soulsby, J. (2001) Needs - led assessment: the challenges and the reality. *Health and Social Care in the Community*. 9 (6), 414 – 428
- Peck, D. F. and Shapiro, C. M. (1990) (Editors) *Measuring Human Problems*. Wiley, Chichester.
- Percy – Smith, J. (Editor) (1996) *Needs assessment in public policy*. Open University Press, Buckingham
- Phelan, M., Slade, M., Thornicroft, G., Dunn, G., Holloway, F., Wykes, T., Strathdee, G., Loftus, L., McCrone, P. and Hayward, P. (1995) The Camberwell Assessment of Need (CAN): the validity and reliability of an instrument to assess the needs of people with severe mental illness. *British Journal of Psychiatry*. 167, 589 – 595
- Phillips, J. and Penhale B. (1996) *Reviewing Care Management for Older People*. London, Jessica Kinglsey
- Postle, K. (2002) Working 'between the idea and the reality': ambiguities and tensions in the care managers' work. *British Journal of Social Work*. 32 (3), 335 – 351
- Potter, P. and Perry, A. (1987) *Basic Nursing, Theory and Practice*. The CV Mosby Company. Missouri. USA
- Poulou, M. (2001) The role of vignettes in the research of emotional and behavioural difficulties. *Emotional and Behavioural Difficulties*. 6 (1), 50 - 62
- Rahman, N. (1996) Caregivers' sensitivity to conflict: the use of the vignette methodology. *Journal of Elder Abuse and Neglect*. 8 (1), 35 – 47

Raven, J. (1999) Managing the unmanageable: risk assessment and risk management in contemporary professional practice. *Journal of Nursing Management*. 7 (4), 201 - 206

Rawlins, P.S., Rawlins, T.D. and Horner, M. (1990) Development of the family needs assessment tool. *Western Journal of Nursing Research*. 12 (2), 201-214

Rein, M. (1969) Research Design and Social Policy. In R, William (Editor) *Distress in the City: Essays on the Design and Administration of Urban Mental Health Services*. Cleveland and London: The Press of Case Western Reserve University

Rew, L. and Barrow, R. M. (1987) Intuition a neglected hallmark of nursing knowledge. *Journal of Advanced Nursing Science*. 10, 49 - 62

Richards, S. (1994) Making sense of needs assessment. *Research, Policy and Planning*. 12 (10), 5 - 9

Ringel, S. (2002) Spontaneous moments and the domain of non verbal communication. *Psychoanalytic Social Work*. 9 (1), 45 – 55

Roberts, K. (2001) Across the health – social care divide: elderly people as active users of health care and social care. *Health and Social Care in the Community*. 9 (2), 100 – 107

Robinson, K. (Editor). (1993) Needs – led assessment: nice idea shame about the reality? *Health and Social Care in the Community*. 1, 115 -123

Robson, C. (1993) *Real World Research: a resource for social scientists and practitioner – researchers*. Oxford, Blackwell Publishers.

Rolland, J. S. (1988) A conceptual model of chronic and life threatening illness and its impact on families. In C.S. Chilman, E. W. Nunnally and F.

M. Cox (Editors.) *Chronic Illness and Disabilities. Families in Trouble Series*. 2. Sage. Beverley Hills

Roper, N., Logan, W. W., Tierney, A. J. (1980) *The Elements of Nursing*. Churchill Livingstone

Royse, D. and Drude, K. (1982) Mental health needs assessment: beware of false promises. *Community Mental Health Journal*. January, 56 - 61

Rummery, K. (1999) The way forward for joint working? Involving primary care in the commissioning of social care services. *Journal of Interprofessional Care*. 13 (3), 207 - 218

Runciman, P. (1989) Health assessment of the elderly at home: the case for shared learning. *Journal of Advanced Nursing*. 14 (2), 111-119.

Scottish Executive Health Department (2000) *Community Care: A Joint Future*. The Stationery Office, Edinburgh

Scottish Executive (2001) *Guidance on single shared assessment of community care needs*. Circular Number: CCD 8/2001

Scottish Executive (2002) *Community Care and Health (Scotland) Act*. The Stationery Office, Edinburgh

Scottish Executive (2003a) *Local Government in Scotland Act*. The Stationery Office, Edinburgh

Scottish Executive (2003b) *Planning for Care – Scotland's Health White Paper*. The Stationery Office, Edinburgh

Scottish Executive (2003) *Local Government in Scotland Act*. The Stationery Office, Edinburgh

Scottish Executive (2004) *Implementing the guidance on care management in community care*. Circular Number: CCD 8/2004

Scottish Executive (2005a) *Building a Health Service Fit for the Future*. The Stationery Office, Edinburgh

Scottish Executive (2005b) *Delivering for Health*. The Stationery Office, Edinburgh

Scottish Executive. (2006) *Response to Care 21 Report: the future of unpaid care in Scotland*. The Stationery Office, Edinburgh

Scottish Office (1998) *Modernising Community Care: An Action plan*. The Stationery Office, Edinburgh

Scottish Executive (2005) *Better Outcomes for Older People: Framework for Joint Services*. The Stationery Office, Edinburgh [www.scotland.gov.uk](http://www.scotland.gov.uk)

Scottish Executive (2006) *Changing Lives: Report of the 21<sup>st</sup> Century Social Work Review*. The Stationery Office, Edinburgh

Secretary of State for Scotland (1997) *Designed to Care: Renewing the National Health Service in Scotland*. The Stationery Office, Edinburgh

Sheaf, R., Pickard, S., Smith, K. (2002) Public service responsiveness to users' demands and needs: theory, practice and primary healthcare in England. *Public Administration*. 80 (3), 435 – 452

Shearer, J. E. (2002) The concept of protection: a dimensional analysis and critique of a theory of protection. *Advances in Nursing Science*. 25 (1), 65 - 78

Sheppard, M. (1986) Primary health care workers views about social work. *British Journal of Social Work*. 16, 459 – 468

Slade, M. (1994) Editorial: Needs assessment: involvement of staff and users will help to meet needs. *British Journal of Psychiatry*. 165, 293 - 296

Slater, P. and McCormack, B. (2005) Determining older people's needs for care by registered nurses: the nursing needs assessment tool. *Journal of Advanced Nursing*. 52 (6), 601 – 608

Smith, A., Maynard, A., Evans, J. G. and Harris, J. (1990) The ethics of resource allocation: proceedings of a symposium held at the University of Manchester during the 33<sup>rd</sup> Annual Scientific Meeting of the Society for Social Medicine, September 1989. *Journal of Epidemiology and Community Health*. 44, 187 - 190

Smith, C. (2001) Trust and confidence: possibilities for social work in high 'modernity'. *British Journal of Social Work*. 31, 287 – 305

Smith, G. (1980) *Social Need Policy, Practice, Research*. Routledge and Kegan Paul Ltd, London.

Smith, J. (1994) Shopping for the right stuff. *Care weekly*. 10 (94), 9

Stalker, K. (1993) The best laid plans...gang aft agley? Assessing population needs in Scotland. *Health and Social Care in the Community*. 2, 1 – 9

Stalker, K. (1994) Implementing care management in Scotland: an overview of initial progress. *Care in Place*. 1 (2), 104 – 119

Stalker, K. (2003) Managing risk and uncertainty in social work: a literature review. *Journal of Social Work*. 3 (2), 211 - 233

Stalker, K. and Campbell, I. (2002) Review of Care Management in Scotland. Health and Community Care Research Findings No 21. Scottish Executive Central Research Unit, Edinburgh

Stevens, A. and Gabbay, J. (1991) Needs assessment needs assessment. *Health Care Trends*. 23, 20 - 23

Stewart, R. (1979) The nature of needs assessment in community mental health. *Community Mental Health Journal*. 15, 287 - 295

Stineman, M. G. (2001) Defining the population, treatments, and outcomes of interest: reconciling the rules of biology with meaningfulness. *American Journal of Physical Medicine and Rehabilitation*. February, 147 - 159

Stoddart, H., Whitley, E., Harvey, I., Sharp, D. (2002) What determines the use of home care services by elderly people? *Health and Social Care in the Community*. 10 (5), 348 - 360

Teresi, J. A. and Holmes, D. (1994) Overview of methodological issues in Gerontological and geriatric medicine. In Lawton, M. P. and Teresi, J. A. (Editors), *Annual Review of Gerontology and Geriatrics*. 14, 1 - 22. Springer, New York

Timms, N. and Timms, R. (1977) Perspectives in Social Work. London, Routledge and Kegan Paul

Toner, H. (1991) What do we mean by assessment? Conference on Diagnosis and Assessment. Dementia Services Development Centre, University of Stirling, 14 May

Torkington, C., Lymbery, M., Millward, A., Murfin, M. and Richell, B. (2004) The impact of shared practice learning on the quality of assessment carried out by social work and district nurse students. *Learning in Health and Social Care*. 3 (1), 26 - 36

Traynor, M. (1994) The views and values of community nurses and their managers: research in progress - one person's pain, another person's vision. *Journal of Advanced Nursing*. 20, 101 - 109



Twigg, J. and Atkin, K. (1994) Carers Perceived. *Policy and Practice in Informal Care*. Open University Press, Buckingham

Twigg, J., Atkin, K. and Perring, C. (1990) *Carers and Services. A Review of Research*. HMSO. London

Vellinga, A., Smit, J.H., Van Leeuwen, E., Van Tilburg, W. and Jonker, C. (2005) Decision-making capacity of elderly patients assessed through the vignette method: imagination or reality? *Ageing and Mental Health*. 9 (1), 40 - 48

Vellinga, A., Smit, J.H., Van Leeuwen, E., Van Tilburg, W. and Jonker, C. (2004) Competence to consent to treatment of geriatric patients: judgements of physicians, family members and the vignette Method. *International Journal of Geriatric Psychiatry*. 19, 645 – 654

Vernon, S., Ross, F. and Gould, M. (2000) Assessment of older people: politics and practice in primary care. *Journal of Advanced Nursing*. 31 (2), 282 - 287

Walker, A. (1993) *Increasing the participation of Older People in social care: a right and a challenge*. Paper presented at the International Conference: Innovation and Participation in Care for the Elderly - Italy meets Europe 20 -22 May

Waterson, J. (1999) Redefining community care social work: needs or risks led? *Health and Social Care in the Community*. 7 (4), 276 – 279

Webb, C. and Kevern, J. (2001) Focus groups as a research method: a critique of some aspects of their use in nursing practice. *Journal of Advanced Nursing*. 33 (6), 798 – 805

Webb, S. (2001) Some considerations on the validity of evidence – based practice in social work. *British Journal of Social Work*. 31, 57 -79

Weinberg, A., Williamson, J, Challis, D. and Hughes, J. (2003) What do care managers do? – A study of working practice in older peoples' services. *British Journal of Social Work*. 33, 901 – 919

West, P. (1982) Reproducing naturally occurring stories: vignettes in survey research. Working paper. Aberdeen: *Medical Research Council*, Medical Sociology Unit

Williams, R. (1999) Managing mental health care: risk and evidence – based practice. *Current Opinion in Psychiatry*. 12 (4), 385 - 391

Williams, M.H. and Bowie, C. (1993) Evidence of unmet need in the care of severely physically disabled adults. *British Medical Journal*. 9 January, 95 - 98

Wilson, J. and While, A. (1998) Methodological issues surrounding the use of vignettes in qualitative research. *Journal of Interprofessional Care*. 12 (1), 79 -87

Wing, J. K. (1986) *The cycle of planning and evaluation, in the provision of mental health services in Britain: the way ahead*. Edited by Wilkinson, G. and Freeman, H. London, Gaskell

Wing, J. K. (1989) The measurement of social disablement: The MRC social behaviour and social role performance schedules. *Soc. Psychiat. Psychiatr. Epidemiology*. 24, 173 – 178

Worth, A. (1996) Identifying need for district nursing: towards a more proactive approach by practitioners. *Nursing Times Research*. 1 (4), 261 - 269

Worth, A. (1998) Community care assessment of older people: identifying the contribution of community nurses and social workers. *Health and Social Care in the Community*. 6(5), 382 – 386

Worth, A. (1999) An ethnographic study of assessment of the needs of older people by district nurses and social workers. PhD Thesis. Glasgow Caledonian University

Worth, A., McIntosh, J., Carney, O. and Lugton, J. (1995) Assessment of need for district nursing. *Research Monograph*. No 1. Glasgow Caledonian University.

Wright, M. (1990) Taking care. *Community Care*. 17 May, 14 – 16

Wykes, T., Creer, C. and Sturt, E. (1982) Needs and deployment of services. In J. K. Wing (Editor), *Long-term Community Care: Experience in a London Burgh*. Psychological Medicine Monograph. Supplement 2

Young, J. (1996) Caring for older people: rehabilitation and older people. *British Medical Journal*. 313 (7058), 677 – 681

Young, G. R. M. (2003) *An exploration of how district nurses construct need and deliver care to older people*. PhD Thesis. Glasgow Caledonian University.

Yura, H. (1986) Human need theory: a framework for the nurse supervisor. *The Health Care Supervisor*. 4 (3), 45 - 58

Yura, H. and Walsh, M. (1988). *The Nursing Process: Assessing, Planning, Implementing and Evaluating*. Fifth Edition. Appleton and Lange. Norwalk, Connecticut

## APPENDIX 1 VIGNETTE GUIDELINES

A vignette is a description of a person or an event and is often used in research to consider attitudes and beliefs.

Vignettes can be used instead of questionnaires: in some cases people find it difficult to verbalise certain beliefs, or it may be that the individual is unaware of the underlying thought processes which result in their final decision. Vignettes can also be used instead of traditional observational research particularly when the researcher finds it difficult to recreate identical situations.

Vignettes will be used in this piece of research in order to identify what aspects or factors influence an individual's assessment of need. A series of vignettes will be developed depicting a typical case scenario. The series of vignettes will concentrate on the same character and situation but at each stage more information will be given thus creating an holistic picture.

In order to develop vignettes several guidelines should be followed:

- The scenario should depict a typical case presentation of an elderly person with dementia living in the community.
- Vignettes should be no more than two or three lines each.
- Language should be clear and easy to follow. Possible misinterpretations should be avoided.
- The scenario depicted should have implications for health and social care staff in the community.
- Needs depicted in the vignette should be kept to a reasonable limit

## APPENDIX 2 BACKGROUND INFORMATION TO THE STUDY

*(For the purposes of members of the VDG)*

Research Question: Needs-led assessment in health and social care: a community-based comparative study

### Introduction

The Community Care reforms of 1990 heralded an era of change in the organisation and delivery of care in the community. Those changes have now become reality and have necessitated a reappraisal of policy and practice for professionals working in health and social care. Community Care reforms call for increased inter-agency collaboration and an approach to assessment which is needs-led as opposed to service-driven.

Community Care for a growing older population, a significant proportion of who suffer from a dementing illness, has significant impact on both health and social services. Adoption of interagency working and needs-led assessment should in theory reduce fragmentation of care packages and provide carers and users with care and support plans which are tailored to suit their needs.

### Study Aim

To consider whether needs-led assessment occurs in the daily practice of community nurses and social work staff dealing with elderly individuals with a variety of needs.

### Objectives

To identify if needs-led assessment occurs in health and social care

To identify certain factors which may influence the assessment of need

To consider differences in the assessment and perception of need by health and social care professionals

## Methodology

### **Target Population**

Data collection will occur in North Glasgow and will include around 40 social work staff and 40 nursing staff. Social work staff will include qualified social workers, social work assistants, O.Ts, O.T assistants, homemakers. Nursing staff will include district nurses, health visitors, CPNs, practice nurses.

### **Inclusion Criteria**

Participants will be expected to complete a brief questionnaire ensuring that the performance of a holistic needs assessment is part of their job description and that this is a responsibility which is carried out on a regular basis.

### **Details of study**

The study seeks to identify whether needs-led assessment is a reality in community care, as practiced by health and social care professionals. Perception of need and subsequent responses can be influenced by a number of factors. These maybe extrinsic and/or intrinsic and may include: professional training, years of experience, area of expertise, awareness of service availability, eligibility criteria, knowledge or control of budget, attitudes toward informal care: all can impact on the assessment and its outcome.

Both health and social care workers in the community have a responsibility to perform needs assessment. Community care legislation stipulates that this should be needs driven. Differences in working culture and language between the two lead agencies may contribute to the fragmentation of community care packages for individuals. Perception of need and approach to the assessment process may also differ.

In order to consider these potential differences in more detail, this study proposes to adopt a vignette approach. Participants will be presented with a sequence of vignettes and asked to identify needs. The sequence will

depict the same scenario each time but will provide the participant with more information which may affect their assessment of need. The vignettes will be carefully constructed by a multidisciplinary planning group who will endeavour to create scenarios reflective of practice and which layers information gradually, allowing the exploration of potential influences as they emerge with each layer. This approach will help to identify whether needs-led assessment is affected by factors such as service availability, presence of informal carer, budgetary restrictions etcetera.

Identification of unmet need may vary between professions and this may be attributed to various factors such as training, perception of risk etcetera. Administration of the vignettes to both nursing and social work staff will allow a comparison to be made. In order for this to be meaningful there is the opportunity to create an ideal response for the scenarios in question. To facilitate this, another multidisciplinary expert assessment group will be set up to generate the gold standard response to each scenario in terms of needs assessed and appropriate responses. This can therefore be compared with individual and collective responses and will be useful in tracking differences in identification of need and perceptions of suitable responses between the two groups.

### APPENDIX 3 VIGNETTE INTERVIEW PREAMBLE

Thank you for agreeing to participate in this study. I plan to interview both health and social care staff and explore the ways in which they identify and assess need.

For the purpose of this interview I will show you a series of case studies following which I will ask you some questions about need and the way in which you identify need.

The interview should last around 30 - 45 minutes and it will be recorded. I will take some brief notes as the interview continues. The information you give will be entirely confidential and will be anonymised.

Before we begin are there any questions you wish to ask me?

Present first vignette



## APPENDIX 4 DRAFT 1: PILOT VIGNETTE

The following case scenario is referred to you for assessment. Consider the situation and respond as you would do within your current caseload. With each vignette you will be given more information about the same situation therefore please avoid stating a 'need for more information' as a response to the question asked.

### Vignette 1

Annie Brown is 74 years old and lives alone in high rise flats. The concierge has returned her to her flat on several occasions when she was found wandering at night. There is evidence of urinary incontinence within the home.

Question 1: From the information given, what issues or areas of need (if any) do you perceive?

Questions 2: (answer only if you have identified need/s from question 1) What action would you take to respond to these issues and meet these needs?

### Vignette 2

Annie Brown is 74 years old and lives alone in high rise flats. The concierge has returned her to her flat on several occasions when she was found wandering at night. There is evidence of urinary incontinence within the home. Her niece, Mary works part-time and usually visits once weekly, but could visit more often dependent on family commitments.

Question 1: From the information given, what issues or areas of need (if any) do you perceive?

Questions 2: (answer only if you have identified need/s from question 1) What action would you take to respond to these issues and meet these needs?

### Vignette 3

Annie Brown is 74 years old and lives alone in high rise flats. The concierge has returned her to her flat on several occasions when she was found wandering at night. Annie previously refused home care due to the charging policy (she may no longer meet new eligibility criteria). Her niece, Mary works part-time and usually visits once weekly, but could visit more often dependent on family commitments. There is evidence of urinary incontinence within Annie's home. There is a Specialist Continence Adviser in the area: the collection point for pads is a five mile journey from Annie's home. You recently received a memo stating that Dementia Day Care availability has been increased locally.

Question 1: From the information given, what issues or areas of need (if any) do you perceive?

Questions 2: (answer only if you have identified need/s from question 1)  
What action would you take to respond to these issues and meet these needs?

### Section 4

From all the information given about this person and within your current caseload what level of priority would you consider this case to be? (Please circle)

High

Medium

Low

### Section 5

Please comment on the vignettes and questions with regards to:

- Level of Information provided
- Clarity of language
- Are questions clear/appropriate?
- Any other comments?

## APPENDIX 5 CHOICE OF VIGNETTES DEVELOPED

### **Vignette Example 1(a)**

Mrs Sharkey is 78 years old and lives alone in a first floor tenement flat. She has recently been diagnosed with mild dementia. She keeps in good health otherwise and until recently has been managing well at home. She now becomes forgetful about shopping lists and is having some difficulty cooking meals. Her weight has decreased as a result.

Mrs Sharkey enjoys going out for walks locally and still maintains friendships with two friends.

### **Vignette Example 1(b)**

Mrs Sharkey's memory continues to decline. She has difficulty preparing food and frequently burns pots on the gas cooker. She has stopped going out alone as she often loses her way. She has lost contact with her friends.

Her daughter, Jane has recently moved into the area and visits three or four times a week. She works part-time and worries about her mother being on her own.

### **Vignette Example 1(c)**

Mrs Sharkey now suffers from moderate to severe dementia and has difficulty managing basic tasks by herself. Her personal hygiene has declined and she often wears inappropriate and sometimes soiled clothing. She can no longer cook for herself and has difficulty ensuring that the gas cooker and fire are switched off.

She tends to be preoccupied about her house keys and will chap on neighbours' doors looking for them. She has started going out alone

during the day and often loses her way. The police have returned her home on several occasions. Jane continues to visit three or four times a week.

### **Vignette Questions**

1. What needs do you think exist?
2. What other aspects should be considered
3. What skills would you use to arrive at this conclusion?
4. What other agencies should become involved?
5. What action should be taken in order to meet these needs?
6. How do you decide what action should be taken?
7. From the list of services/interventions available, identify those you consider appropriate (extensive list and minimalist list)?
8. How would you define need and the assessment thereof?

### **Vignette Example 2(a)**

James is 68 years old and lives with his wife Jean in their terraced house. He was recently diagnosed with mild dementia. He has difficulty coming to terms with the diagnosis particularly as he worked as a self-employed joiner until he was 67 years old. He still enjoys carpentry as a hobby and spends several hours a day in his work shed.

James is reluctant to go out on his own because he is embarrassed about his memory loss. He finds it difficult remembering names and following conversations. He insists on his wife being there whenever he goes out. She does not always have the time to go with him.

### **Vignette Example 2(b)**

James' memory continues to deteriorate. He also experiences some personality changes. He becomes agitated easily and frequently loses his temper with his wife. Jean needs to prompt him to wash and dress and helps him in and out of the bath because he is prone to slip. He has had

several accidents with work tools and Jean worries whenever he is in the work shed on his own.

Jean has become depressed about the situation at home. She complains of feeling helpless and is frightened by her husband's emotional outbursts. He frequently tells her that he is bored with her company.

### **Vignette Example 2(c)**

James now suffers from moderate to severe memory loss and this is associated with some behavioural changes. He experiences some delusions and often accuses family members of stealing things. He has become verbally and at time physically abusive towards his wife. This usually happens when she prompts him to do things or tries to prevent him from going out alone.

James' mobility has deteriorated and he now walks with a stick. He can only walk short distances and is frustrated that he can't get out as much as he would like.

### **Vignette Questions**

1. What needs do you think exist?
2. What other aspects should be considered?
3. What skills would you use to arrive at this conclusion?
4. What other agencies should become involved?
5. What action should be taken in order to meet these needs?
6. How do you decide what action should be taken?
7. From the list of services/interventions available identify those you consider appropriate (extensive list and minimalist list)?
8. How would you define need and the assessment thereof?

### **Vignette Example 3(a)**

Liz is 76 years old and suffers from mild dementia. She lives with her husband, Ben in a top floor flat. She mobilises with a walking stick and enjoys going out for short walks. She relies on Ben to go with her. He suffers from arthritis and cannot always go with his wife.

Liz is incontinent of urine and does not know how to manage this. She also has difficulty getting in and out of the bath. Ben used to help her but is now unable because of the arthritis.

### **Vignette Example 3(b)**

Liz now suffers from moderate dementia and her mobility has deteriorated. She often loses her balance even with the walking stick and has fallen twice in the last 3 months. Ben has had to call on neighbours to help get her up. She is frequently incontinent overnight despite attempting to get up and go to the bathroom. Ben now sleeps poorly because he is afraid she will fall overnight.

Ben can no longer provide the level of physical support that Liz requires when she is out therefore she is practically housebound. She is becoming increasingly depressed about this.

### **Vignette Example 3(c)**

Liz's dementia continues to worsen as does her physical condition. She now requires assistance to mobilise and to transfer from her bed to a chair. She is unable to wash or dress herself. She is completely incontinent of urine and is prone to bladder infections.

Ben is unable to provide the help that his wife requires because of his arthritis. He is now unable to leave Liz on her own at all. He is unable to go out shopping, collect the pension etcetera. He feels that she is very depressed and misses the company of others.

## **Vignette Questions**

- What needs do you think exist?
- What other aspects should be considered?
- What skills would you use to arrive at this conclusion?
- What other agencies should become involved?
- What action should be taken in order to meet these needs?
- How do you decide what action should be taken?
- From the list of services/interventions available identify those you consider appropriate (extensive list and minimalist list)?
- How would you define need and the assessment thereof?

## **Vignette Example 4(a)**

Mr Rooney suffers from mild dementia and lives alone on the 17<sup>th</sup> floor of high rise flats. He keeps in good health and attends local lunch clubs. His daughter works full-time and visits once a week. He is having difficulty remembering when to take his medication and is therefore complying poorly.

## **Vignette Example 4(b)**

Mr Rooney's memory has worsened and he has difficulty cooking meals for himself. He burns pots etcetera and has had a small fire in the kitchen. Neighbours are concerned about his safety living alone. Mr Rooney is reluctant to receive help and is of the opinion that his daughter ought to look after him. She has difficulty visiting on a regular basis because she works full-time.

Mr Rooney rarely goes out and has not collected his pension for several weeks. His daughter believes he has money hidden in the house. Mr Rooney claims that local youths have been stealing money from him.

### **Vignette Example 4(c)**

Mr Rooney now suffers from moderate to severe dementia. He has difficulty managing finances and is no longer able to cook meals for himself. He appears to be hallucinating and has some fixed delusions, mainly about his daughter stealing from him and removing things from his house.

He is unable to go out alone as he has become lost on several occasions. The concierge tries to look out for him but still Mr Rooney has gone out wandering, only to be returned home by the police several hours later. His daughter is extremely distressed by the situation and has been signed off work sick. She has also been commenced on antidepressants by her GP.

### **Vignette Questions**

1. What needs do you think exist?
2. What other aspects should be considered?
3. What skills would you use to arrive at this conclusion?
4. What other agencies should become involved?
5. What action should be taken in order to meet these needs?
6. How do you decide what action should be taken?
7. From the list of services/interventions available identify those you consider appropriate (extensive list and minimalist list)?
8. How would you define need and the assessment thereof?

### **Comprehensive Service List**

- Home help
- Meals on Wheels
- Home Befriender
- General Day care
- Specialist Dementia Day care
- Evening and Over night support



- Sheltered Housing
- Residential Care
- Nursing Home Care
- Respite Care
- Advocacy
- Hospital Care
- Dementia Support Group
- Carers support group
- Information sheets about the disease and where to get help

### **Aids and Adaptations**

- Wheelchair
- Walking Stick
- Glasses
- Hearing Aid
- Bath aids
- Raised Toilet Seat
- Community Alert Alarm
- Smoke detector
- Isolation valve for gas cooker or fire
- Fire guard
- Incontinence pads
- Commode

### **Professionals' list**

- Social Worker
- District Nurse
- Health Visitor
- Practice Nurse
- OT
- Welfare Benefit Officer
- Mental Health Officer
- Alzheimer Scotland Action on Dementia

- Geriatrician
- Psychogeriatrician
- CPN
- Chiropodist
- Physiotherapist
- Counsellor
- GP
- Continence facilitator

## APPENDIX 6 RESEARCH STUDY PARTICIPANT QUESTIONNAIRE, VIGNETTE AND QUESTIONS

1. Do you perform individual needs assessment regularly? Yes/No
2. Area of work – from the following lists identify your professional designation and where appropriate grade:

### **(a) Community Nursing**

- District Nurse
- Health Visitor
- CPN
- Practice Nurse
- Community Staff Nurse
- Community Health Care Assistant
- Other – please specify

### **(b) Social Work**

- Senior Social Worker
- Social Worker
- Social Work Assistant
- OT
- Occupational Therapy Assistant
- Homemaker
- Home Help Organiser
- Other – please specify

### **(c) GP**

### **3. Personal Details**

- Age

- Sex
- Length of employment in current post

#### **4. Training**

- Time since qualified
- Duration of basic training course for current post or profession

## **Vignette and Semi-structured Interview**

Please read the following case scenario as if you were about to carry out an assessment. Unless otherwise stated you are to assume that no formal services are involved.

### **Vignette (a)**

Jean is 76 years old and suffers from mild dementia. She lives with her husband, Bob in a top floor flat. She mobilises with a walking stick and enjoys going out for short walks. She relies on Bob to go with her. He suffers from arthritis and cannot always go with his wife.

Jean is incontinent of urine and does not know how to manage this. She also has difficulty getting in and out of the bath. Bob used to help her but is now unable because of the arthritis.

1. What needs do you think exist?
2. What other aspects should be considered?
3. What skills would you use to arrive at this conclusion?
4. What other agencies should become involved?
5. What action should be taken in order to meet these needs?
6. How do you decide what action should be taken?
7. What factors influence your assessment of need?

### **Vignette (b)**

Jean now suffers from moderate dementia and her mobility has deteriorated. She often loses her balance even with the walking stick and has fallen twice in the last 3 months. Bob has had to call on neighbours to help get her up. She is frequently incontinent overnight despite attempting to get up and go to the bathroom. Bob now sleeps poorly because he is afraid she will fall overnight.

Bob can no longer provide the level of physical support that Jean requires when she is out therefore she is practically housebound. She is becoming increasingly depressed about this.

1. What needs do you think exist?
2. What other aspects should be considered?
3. What skills would you use to arrive at this conclusion?
4. What other agencies should become involved?
5. What action should be taken in order to meet these needs?
6. How do you decide what action should be taken?
7. What factors influence your assessment of need?

### **Vignette (c)**

Jean's dementia continues to worsen as does her physical condition. She now requires assistance to mobilise and to transfer from her bed to a chair. She is unable to wash or dress herself. She is completely incontinent of urine and is prone to bladder infections.

Bob is unable to provide the help that his wife requires because of his arthritis. He is now unable to leave Jean on her own at all. He is unable to go out shopping, collect the pension etcetera. He feels that she is very depressed and misses the company of others.

1. What needs do you think exist?
2. What other aspects should be considered?
3. What skills would you use to arrive at this conclusion?
4. What other agencies should become involved?
5. What action should be taken in order to meet these needs?
6. How do you decide what action should be taken?
7. What factors influence your assessment of need?

## **SPECIFIC QUESTIONS**

**1.** From the list of services available identify those that you consider appropriate

### **Services**

- Home help
- Meals on wheels
- Home Befriender
- General day care
- Specialist dementia day care
- Evening and overnight support
- Sheltered housing
- Residential care
- Nursing home care
- Respite care
- Advocacy
- Hospital care
- Dementia sufferers support group
- Dementia carers support group
- Information sheets about the disease

### **Aids & Adaptations**

- Wheelchair
- Walking stick
- Walking frame
- Glasses
- Hearing aid
- Bath aids
- Raised toilet seat
- Community alert alarm
- Smoke detector
- Isolation valve for gas cooker or fire
- Fire guard
- Incontinence pads

- Commode
- Dausset box
- Cotsides

### **Professionals List**

- Social worker
- District nurse
- Health visitor
- Practice nurse
- OT
- Welfare benefits officer
- Mental health officer
- Alzheimer Scotland Action in Dementia
- Geriatrician
- Psychogeriatrician
- CPN
- Chiropodist
- Physiotherapist
- Counsellor
- GP
- Continence facilitator
- Chemist

**2.** What factors influence your assessment of need?

**3.** How would you define need – and – how would you define assessment?



## APPENDIX 7 RESEARCH STUDY PARTICIPANT QUESTIONNAIRE, VIGNETTE AND QUESTIONS

1. Do you perform individual needs assessment regularly? Yes/No
2. Area of work – from the following lists identify your professional designation and where appropriate grade:

### **(a) Community Nursing**

- District Nurse
- Health Visitor
- CPN
- Practice Nurse
- Community Staff Nurse
- Community Health Care Assistant
- Other – please specify

### **(b) Social Work**

- Senior Social Worker
- Social Worker
- Social Work Assistant
- OT
- Occupational Therapy Assistant
- Homemaker
- Home Help Organiser
- Other – please specify

### **(c) GP**

### **3. Personal Details:**

- Age
- Sex
- Length of employment in current post

#### **4. Training**

- Time since qualified
- Duration of basic training course for current post or profession

## **Vignette and Semi-structured Interview**

Please read the following case scenario as if you were about to carry out an assessment. Unless otherwise stated you are to assume that no formal services are involved.

### **Vignette (1)**

Jean is 76 years old and suffers from mild dementia. She lives with her husband, Bob in a top floor flat in a high rise building. She mobilises with a walking stick and enjoys going out for short walks. She relies on Bob to go with her. He suffers from arthritis and cannot always go with his wife.

Jean is incontinent of urine and does not know how to manage this. She also has difficulty getting in and out of the bath. Bob used to help her but is now unable because of the arthritis.

### **Vignette Questions (General)**

### **Vignette No 1**

1. What needs do you think exist?
2. How do you identify these needs? (Do you apply a particular model of assessment of need?)
3. What other aspects should be considered?
4. What would you do in order to address these needs?
5. What factors influence the extent to which you are able to address these needs?
6. What other agencies should become involved?

### **Vignette (2)**

Jean's dementia has worsened. She can no longer help with housecare and relies heavily on Bob. Her mobility has deteriorated and she has had several falls. She is frequently incontinent overnight. Bob worries that might fall on her way to the bathroom and therefore he sleeps poorly. Her

personal hygiene has also deteriorated and Bob is unable to help her in and out of the bath.

Bob can no longer provide the support that Jean needs in order to go out therefore she is practically housebound. She is becoming depressed about this.

### **Vignette Questions (General)**

### **Vignette No 2**

1. What needs do you think exist?
2. How do you identify these needs? (Do you apply a particular model of assessment of need?)
3. What other aspects should be considered?
4. What would you do in order to address these needs?
5. What factors influence the extent to which you are able to address these needs?
6. What other agencies should become involved?

### **Vignette Questions (Specific)**

1. From the list of services available identify those you consider appropriate? (refer to Comprehensive List below)
2. What factors influence your assessment of need?
3. How would you define need and the assessment thereof?
4. Do you think there are differences in the way that health professionals assess need and the way that social care professionals assess need? Please discuss.

## **Comprehensive Resource List**

From the following lists of services, professionals and equipment and adaptations please identify those elements you would ensure would be in place following Vignette 2

### **Service List**

- Home help
- Meals on Wheels
- Home Befriender
- General Day care
- Specialist Dementia Day care
- Evening and Over night support
- Sheltered Housing
- Residential Care
- Nursing Home Care
- Respite Care
- Advocacy
- Hospital Care
- Dementia Sufferers Support Group
- Dementia Carers support group
- Information sheets about the disease and where to get help

### **Equipment and Adaptations**

- Wheelchair
- Walking Stick
- Walking Frame
- Glasses
- Hearing Aid
- Bath aids
- Raised Toilet Seat
- Community Alert Alarm
- Smoke detector
- Isolation valve for gas cooker or fire
- Fire guard

- Incontinence pads
- Commode
- Dossett Box
- Cotsides

### **Professionals' list**

- Social Worker
- District Nurse
- Health Visitor
- Practice Nurse
- CPN
- Welfare Benefit Officer
- Mental Health Officer
- Alzheimer Scotland Action on Dementia
- Geriatrician
- Psychogeriatrician
- Chiropodist
- Physiotherapist
- Counsellor
- OT
- GP
- Continence facilitator
- Chemist

## APPENDIX 8 RESPONSES IDENTIFIED FROM GSG REGARDING NEEDS AND INTERVENTIONS

### **Vignette (1)**

Jean is 76 years old and suffers from mild dementia. She lives with her husband, Bob in a top floor flat in a high rise building. She mobilises with a walking stick and enjoys going out for short walks. She relies on Bob to go with her. He suffers from arthritis and cannot always go with his wife.

Jean is incontinent of urine and does not know how to manage this. She also has difficulty getting in and out of the bath. Bob used to help her but is now unable because of the arthritis.

### **Needs Identified for Vignette (1)**

- Cognitive State (orientation and memory)
- Urinary Incontinence
- Personal Hygiene
- Social Isolation
- Carer's Needs

### **Actions to be taken/professional responses for Vignette (1):**

#### Cognitive State (orientation and memory)

- Cognitive assessment e.g. Mini Mental State Exam by health professional
- Referral to GP or Consultant for physical and mental health assessment to eliminate acute confusion and/or depression as a cause of memory loss
- Establish a history of cognitive decline
- Consider compliance with medication – poor compliance may precipitate decline in cognitive state
- Gather information from appropriate agencies

- Discuss with the client her thoughts regarding cognitive decline

#### Urinary Incontinence

- Collect Mid Stream Specimen of Urine
- Visit client at home
- Establish cause of urinary incontinence
- Identify client's level of insight into incontinence and discuss her desire for treatment/investigation/management
- Provide pads and pants if required
- Referral to GP or Nurse Specialist for specialist assessment
- Contact health visitor, Continence Nurse Specialist or Physiotherapist depending on cause
- Assess diet and fluid intake
- Check compliance with existing continence garments
- Facilitate treatment of cause if appropriate
- Check past medical history involving medical record and laboratory results
- Assess home situation e.g. access to toilet
- Assess client's mobility
- Contact other relevant agencies already involved to ascertain history on progress

#### Personal Hygiene

- Consider skin integrity
- Consider client's ability to wash and bathe
- Identify client's wishes/preferences regarding support to wash and/or bathe
- Consider the bathroom facilities: access to sink and into bath
- Refer to OT for assessment for bathing equipment and possibly adaptations
- Consider client's ability (mentally and physically) to bathe using equipment
- Consider support provided by formal and informal carers (actual and potential)



### Social Isolation

- Consider whether client considers themselves socially isolated
- Consider client's personality and wishes/preferences for social stimulation
- Consider client's ability (mental and physical) to engage in social activities
- Consider structural and environmental issues including ease of access in and from the building
- Consider client's awareness of available resources and desire to use them
- Consider accessibility of available resources
- Consider mental health issues e.g. client may be depressed or anxious about socialising
- Consider safety of area outwith the flat e.g. there may be a high crime rate
- Consider orientation to time and place
- Consider client's social circumstances and past social history
- Contact local agencies already involved

### Carer's Needs

- Consider support provided by informal carer.
- Identify any difficulties experienced by carer in relation to his own health needs and the impact of caring for his wife
- Consider carer's willingness and ability to continue providing support for his wife
- Consider carer's preferences for support and service intervention
- Consider carer stress levels
- Consider the carer's need for a break (short and long-term)
- Consider carer's awareness of support including availability and access
- Identify any additional support provided by other informal carers.
- Ensure a carer's assessment is carried out

Following identification of needs and actions the Gold Standard Response group then considered Vignette 2 and identified the following areas.

## **Vignette (2)**

Jean's dementia has worsened. She can no longer help with housecare and relies heavily on Bob. Her mobility has deteriorated and she has had several falls. She is frequently incontinent overnight. Bob worries that might fall on her way to the bathroom and therefore he sleeps poorly. Her personal hygiene has also deteriorated and Bob is unable to help her in and out of the bath.

Bob can no longer provide the support that Jean needs in order to go out therefore she is practically housebound. She is becoming depressed about this.

## **Needs Identified for Vignette (2)**

In general the needs and requirement for action were considered to be of higher priority. The focus of professional attention was shared more equally between the client and the carer's needs. The following areas of need were identified:

- Mental Health (including mood and cognitive state)
- Urinary Incontinence
- Personal Hygiene
- Housing (including housecare)
- Mobility
- Social Isolation
- Carer's Needs

## **Action to be taken/professional responses for Vignette (2)**

### Mental Health (including mood and cognitive state)

- Cognitive assessment e.g. Mini Mental State Exam by health professional
- Assess level of depressed mood

- Identify potential cause/s of depressed mood
- Referral to GP or Consultant for physical and mental health assessment to eliminate acute confusion and/or depression as a cause of memory loss and to consider client's depressed mood.
- Establish a history of cognitive decline
- Establish a history of depressed mood including initiating factors if identifiable
- Consider compliance with medication – poor compliance may precipitate decline in mood and cognitive state
- Gather information from appropriate agencies
- Discuss with the client her thoughts regarding cognitive decline and depressed mood
- Consider the use of medication to manage cognitive decline and depressed mood
- Consider client's ability to make informed choices about her needs and the support she receives

#### Urinary Incontinence

- Collect Mid Stream Specimen of Urine
- Visit client at home
- Establish cause of urinary incontinence
- Identify client's level of insight into incontinence and discuss her desire for treatment/investigation/management
- Provide pads and pants if required
- Referral to GP or Nurse Specialist for specialist assessment
- Contact health visitor, Continence Nurse Specialist or Physiotherapist depending on cause
- Assess diet and fluid intake (particularly in evenings)
- Consider daily routines including visits to the bathroom
- Check compliance with existing continence garments
- Facilitate treatment of cause if appropriate
- Check past medical history involving medical record and laboratory results
- Assess home situation e.g. access to toilet
- Assess client's mobility

- Contact other relevant agencies already involved to ascertain history on progress

### Personal Hygiene

- Consider skin integrity
- Consider client's ability to wash and bathe
- Identify client's wishes/preferences regarding support to wash and/or bathe
- Consider the bathroom facilities: access to sink and into bath
- Refer to OT for assessment for bathing equipment and possibly adaptations
- Consider client's ability (mentally and physically) to bathe using equipment
- Consider support provided by formal and informal carers (actual and potential)

### Housing

- Consider suitability of housing
- Identify client and carer's wishes with regards to continuing to live in current accommodation and option to consider alternative housing
- Identify specific issues relating to difficulty with housecare and subsequent areas e.g. shopping, collecting pension
- Ensure a benefits check has been carried out and benefits maximised
- Consider support currently provided within the house by both formal and informal carers
- Identify preferences and wishes of both client and carer with regard to receiving support to maintain the house
- Refer to Occupational Therapy for an assessment of ability to manage within current accommodation
- Consider physical safety hazards within the home

### Mobility

- Refer to GP for investigation of cause of falls

- Ensure full physical health check is carried out
- Refer to Physiotherapist for a full mobility and provision of equipment and/or rehabilitation if considered appropriate
- Provide equipment and consider adaptations to home to ensure mobility is maintained at an optimum
- Refer to Occupational Therapy for an assessment of ability to manage within current accommodation

#### Social Isolation

- Consider whether client considers themselves socially isolated
- Consider client's personality and wishes/preferences for social stimulation
- Consider client's ability (mental and physical) to engage in social activities
- Consider structural and environmental issues including ease of access in and from the building
- Consider client's awareness of available resources and desire to use them
- Consider accessibility of available resources
- Consider mental health issues e.g. client may be depressed or anxious about socialising
- Consider safety of area outwith the flat e.g. there may be a high crime rate
- Consider orientation to time and place
- Consider client's social circumstances and past social history
- Contact local agencies already involved

#### Carer's Needs

- Consider support provided by informal carer.
- Identify any difficulties experienced by carer in relation to his own health needs and the impact of caring for his wife
- Consider carer's willingness and ability to continue providing support for his wife
- Consider carer's preferences for support and service intervention
- Consider carer stress levels

- Consider the carer's need for a break (short and long-term, temporary and permanent)
- Consider carer's awareness of support including availability and access
- Identify any additional support provided by other informal carers.
- Ensure a carer's assessment is carried out
- Ensure a financial assessment is carried out with the carer and that all benefits are maximised

## APPENDIX 9 PARTICIPANT REQUEST LETTER

Kirsteen Cameron  
Research & Development Officer (Joint Future)  
South West Glasgow LHCC  
First Floor  
Clutha House  
120 Cornwall Street South  
Kinning Park  
Glasgow  
G41 1AD  
Tel: 0141 427 8264  
Email: [kirsteen.cameron@glacomen.scot.nhs.uk](mailto:kirsteen.cameron@glacomen.scot.nhs.uk)

Dear

Re: staff interviews for thesis

I am currently undertaking a PhD (part-time) at the Nuffield Centre for Community Care Studies (Glasgow University). I am considering the approach taken to needs-led assessment between health and social work staff and in particular looking at the various factors which influence our assessments of older people. To do this I have been interviewing practitioners (social workers, CPNs, district nurses, health visitors etc) across the north of Glasgow. The interviews involve consideration of two case studies and several questions about your approach to assessing need. The interviews are completely confidential and anonymous and take between 30 - 45 minutes.

I would be grateful if you might consider participating. A time and venue can be arranged at your convenience and I can be contacted at the above address/phone number to arrange a time. I will follow this letter with a

telephone call in the next few weeks but should you wish more information before making a decision please do not hesitate to contact me at the above number or email address.

Kind Regards

Kirsteen Cameron